**Family Centered Care in the Emergency Department**

**Introduction:**

Family members are a major psychological support system for patients requiring emergency medical treatment. This is especially true for children. Family member presence should never be forced upon either the family or emergency department (ED) staff if it may interfere with providing optimal care to the child. The priority remains the expeditious and appropriate treatment of the child.

**Background: Elements of Family Centered Care**

* The family is the constant in a child’s life, while the role and importance of health care and social service systems vary and the people staffing those systems change
* Families often wish to be with their loved ones during intensely stressful times.
* Family presence in the treatment area during resuscitation or the performance of procedures is generally beneficial to both the patient/child and family.
* Emergency providers can aid in family interactions by instructing family members regarding the most appropriate place to stand or sit.
* Family members may be encouraged to speak with, touch, comfort, and soothe patients/children during procedures as appropriate, provided they do not impede access, or interfere with the care being provided to the patient.
* Family members can be advised as to those actions that are considered inappropriate or disruptive (sterile field, movements, etc.).

Patients and families deserve active participation in the decision-making process involved in the provision of their medical care. This includes detailed education and instruction regarding the rationale behind various diagnostic or therapeutic regimens, alternatives, advantages and disadvantages, risks and benefits

**Purpose:**

To provide guidelines for family presence during care, discharge planning and education of the patient, family, and regular caregivers.

**Family Presence During Resuscitation and Invasive Procedures:**

* During the triage/admission process the child’s family members will be identified.
* Family members will receive identification indicating the child’s name, the family member’s name, and his/her relationship.
* Family members will be provided with updates on the process of flow through the ED from triage to discharge.
* During resuscitation, an ED staff member or support person serves as family facilitator. The family facilitator receives special training in family presence and is responsible solely for the care of the family members during the provision of care to the child.

**Exceptions to Family Presence**

There may be times during the ED visit when family presence is not appropriate. The Charge Nurse, in conjunction with the ED physician and family facilitator (if present) have the authority to ask a family to leave the treatment area under certain circumstances.

Family presence may be restricted when:

* Family is emotionally distraught and unable to comfort the child.
* Family interferes with the ability to provide patient care.
* Family presence interferes with the confidentiality or care of another patient.
* If the patient is over 14 years of age and prefers that no family member be present during care.
* NOTE: The family facilitator role is extremely important during restrictive family presence times.

Quality indicators of family presence closely mirror those measuring satisfaction with healthcare delivery. Common indicators of a quality ED experience include:

* Feelings of being treated with dignity and respect.
* Having a measure of autonomy in the course of treatment.
* Having one’s confidentiality respected and protected.
* Speed of access – prompt medical attention.
* Receiving access to social/family support.
* Quality of interpersonal communication with healthcare providers.
* Completeness of Discharge Planning, Education and Instruction
* Chart review for completeness of documentation.
* Chart review for appropriateness of instructions, education materials, and follow-up referrals

**Children with Special Healthcare Needs**

Children with special healthcare needs (CSHCN) are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. These children are particularly complex in terms of their past medical history, their requirements for more invasive procedures, and their inability to communicate or advocate for themselves. *It is therefore particularly important that their family members are allowed to act as their advocate, and in doing so actively participate in their care.*

**Cultural Sensitivity Issues**

Special attention may be necessary to maintain cultural sensitivity in terms of privacy, gender, and age. Certain cultures require presence or absence of certain genders during sensitive procedures such as anogenital or breast examinations. Certain cultures may appear less willing or interested in being present during invasive procedures or the process of resuscitation. That preference should be respected. It does not necessarily equate with being disinterested. Rather, it may represent a cultural diversity.

**Disagreements Regarding Family Presence**

Occasionally there may be a disagreement about family presence during pediatric emergency care. However, delays in care should not occur because of discussion related to relatives remaining in the room. If a family member must be removed from a treatment area, often the need for such a drastic measure can be addressed after the patient is stabilized. However, these disagreements are rare, and generally there is time for a brief discussion to resolve both family member and medical personnel concerns. In most instances, an open dialogue with the family will lead to a rapid resolution of the disagreement or an agreeable compromise. Even when medical personnel feel strongly it is inappropriate for family members to be present, assurance the family will be permitted to return to the bedside as soon as the procedure is completed often alleviates their concerns.

**Joint Commission Standards**

RI.1.2 Patients are involved in all aspects of their care

RI.1.2.2 The family participates in care decisions

RI.1.3 The hospital demonstrates respect for the following patient needs: confidentiality, privacy, security, resolution of complaints, pastoral counseling and communication.

**Sources:**

ACEP Talking Points: Family Member Presence in the Emergency Department

Emergency Nurses Association Position Statement: Family Presence During Resuscitation

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