



ARAŞTIRMA MAKALESİ  
RESEARCH ARTICLE  
CBU-SBED, 2021, 8(4): 649-656

## Parents Views on Being with Their Children During the Process of Resuscitation: Intensive Care Unit Example

### Ebeveynlerin Canlandırma Sırasında Çocuklarının Yanında Bulunmaya İlişkin Görüşleri: Yoğun Bakım Ünitesi Örneği

Bahar Yatkın<sup>1</sup>, Aysel Kökcü Doğan<sup>2\*</sup>, Sema Kuşoğlu<sup>2</sup>

<sup>1</sup>Medipol Mega University Hospital, Neonatal Intensive Care Unit, Istanbul, Turkey.

<sup>2</sup>Istanbul Medipol University, Faculty of Health Sciences, Nursing Department, Istanbul, Turkey.

e-mail: Bahar.ytkn93@gmail.com, akdogan@medipol.edu.tr, skuguoglu@medipol.edu.tr.

ORCID: 0000-0002-5307-8042

ORCID: 0000-0003-3312-087X

ORCID: 0000-0002-2794-1068

\*Sorumlu yazar/ Corresponding Author: Aysel Kökcü Doğan

Gönderim Tarihi / Received: 27.03.2021

Kabul Tarihi / Accepted: 10.11.2021

DOI: 10.34087/cbusbed.904469

#### Öz

**Giriş ve Amaç:** Bu çalışma, ebeveynlerin canlandırma sırasında çocuklarının yanında bulunmaya ilişkin görüşlerini belirlemek amacıyla, tanımlayıcı ve metodolojik olarak yapılmıştır.

Klinik çalışmalarda etkinliği kanıtlanmış olmasına rağmen, daratumumabın gerçek yaşam verilerinden elde edilen literatür bilgileri ülkemizde oldukça sınırlıdır. Bu nedenle merkezimizde daratumumab ile tedavi edilen hastaların karakteristik özelliklerini ve yanıt oranlarını incelemeyi amaçladık.

**Gereç ve Yöntemler:** Araştırmanın evrenini, İstanbul'daki özel bir üniversite hastanesinin bebek ve çocuk yoğun bakım ünitelerinde bebek ve çocukları yatan ebeveynler, örneklemi ise Haziran 2018-Şubat 2019 tarihleri arasında araştırmaya katılmaya gönüllü olan 222 ebeveyn oluşturmuştur. Veriler, araştırmacılar tarafından "Tanıtıcı Bilgi Formu" ve "Canlandırma Sırasında Ebeveyn Görüşlerine İlişkin Veli Görüş Formu" (cronbach alpha: .85) ile toplanmıştır. Çalışmada elde edilen veriler lisanslı SPSS (Statistical Package for Social Sciences) Windows 22.0 programı kullanılarak analiz edilmiştir.

**Bulgular:** Araştırma kapsamında; ebeveynlerin canlandırma odasında bulunmak istedikleri (%64.0), daha önce yaşamını kaybeden bir yakınının canlandırma işlemine tanıklık etmedikleri (%88.3), sağlık çalışanlarının konuya ilişkin eğitim almasını düşündükleri (%89.2), canlandırma odasında bulunmalarının çocuklarına yapılması gereken tüm uygulamaların yapıldığına inanmalarını sağlayacağı (%76,6), canlandırma işleminden sonra çocuklarıyla vedalaşmak için uygun bir ortam bekledikleri (%78,4), ailelerin canlandırma odasında buldukları takdirde sağlık çalışanları tarafından desteklenmeyi bekledikleri (%84,2), sağlık kurumlarında ailelere yönelik canlandırma prosedürleri geliştirilmesini istedikleri (%85,6) saptanmıştır.

**Sonuç:** Bulgular, sağlık kurumlarında çocukların canlandırma odasında ebeveynlerinin bulunmasına yönelik kapsamlı protokol ve prosedürlerin geliştirilerek standardize edilmesi, gerektiğini göstermektedir.

**Anahtar kelimeler:** Canlandırma, Çocuk, Ebeveyn.

#### Abstract

**Objective:** The study was made descriptively and methodologically to determine parents' views about being with their children during the resuscitation.

**Materials and Methods:** The study's universe was the parents whose infants and children were staying in the pediatric intensive care units of a private university hospital in Istanbul, and the sample consisted of 222 parents who volunteered to participate in the study between June 2018 and February 2019. The data were collected with "Introductory Information Form" and "Parents' Opinion Form Regarding Parents' Views During Resuscitation" (cronbach alpha: .85) by the researchers. The data obtained in the study were analyzed using the licensed SPSS (Statistical Package for Social Sciences) for Windows 22.0 program.

**Results:** Within the scope of the research, parents; that want to be in the resuscitation room (64.0%), parents who have lost their relatives before, but have not witnessed the resuscitation process (88.3%), parents who thought that the healthcare professionals should receive training on the subject (89.2%), parents who believe that all the applications required to be performed to their children in the resuscitation room were made. (76.6%), parents who expect a suitable environment to say goodbye to their children after the resuscitation (78.4%), parents expecting to be supported by healthcare workers when they are in resuscitation rooms (84.2%), parents who demand improvements in revitalization procedures for families in healthcare institutions (85.6%) were determined respectively.

**Conclusion:** Results demonstrate that comprehensive procedures and protocols for presence of the children's parents in the children's resuscitation rooms in health institutions should be developed and standardized.

**Keywords:** Child, Parent, Resuscitation.

## 1. Introduction

The resuscitation process is a sophisticated attempt to bring the individual back to life. During this attempt, the patient is in the intervention room, while the family is in a separate crisis room and, in a hurry, waits for the outcome and future status information about their relatives. Considering a resuscitation that ends with losing a patient, the family is allowed to meet with the lost patient by recovering the patient and the room. During this time, the family is not aware of the interventions and the situation of the relative. With the family-centered care, this traditional approach has considered as being incorrect [7, 13, 14, 16, 23, 27].

It is almost impossible to think of family members separately from patients, especially in the approach to pediatric patients. Separating them is a cause of anxiety for both the family and the child. While this process can be sustained much easier for outpatient and inpatient children, intensive care units unfortunately completely separate the family from the child if it is not a child-friendly unit. In any process, even if it is a closed area such as intensive care, the unit served should not be considered separate from the child's family. Considering the existence of patients who have been struggling to survive for a long time in intensive care units, it is a big mistake to keep families entirely out of the process. Already this situation causes a significant burden for the families, and the fear and anxiety they experience will increase when they are isolated away from their offspring [4, 9, 17, 21].

When the initiative is concluded, being with them in their struggle and feeling for them and support them positively affect the family. Even if the result is negative, they can have the opportunity to say goodbye to their children at the last moment. This scene shortens the process of accepting and grieving the family situation. Also, family members who were taken to the room during the resuscitation proved to have fewer symptoms of posttraumatic stress disorder, anxiety, depression, and grief [1-3, 10, 12, 13, 19, 20, 23-26].

Most of the families who are present during the resuscitation think that they support the healthcare team and their children who are in a difficult situation by staying in the room even if the child does not live and argue that this is the right of all families [13, 29].

Despite these demands of families, unfortunately, there is no written procedure in institutions. Written procedures to assist the healthcare worker should be

established during the resuscitation and should guide the healthcare professionals [8].

The study aims to determine the views of parents about being with their children during the resuscitation.

## 2. Materials and Methods

### 2.1. Aim of Research

The study was conducted methodologically to determine parents' views about being with their children during resuscitation.

### 2.2. Location and Time of Research

The research was carried out between June 2018 and February 2019 in neonatal and child intensive care units of a private hospital in Istanbul.

### 2.3. The Population and Sample of the Research

The population in the research between June 2017 and February 2018, a total of 777 parents of 688 babies and children applied to pediatric intensive care units of a private hospital and 222 parents who volunteered to participate in the study.

### 2.4. Data Collection Technique

The necessary explanations were made to the parents about the "Form of Determining Parents' Opinions about Being with Their Children During Resuscitation" and "Introductory Information Form.". Their consents were obtained, and the data were collected by the researcher in a quiet and calm environment by the method of meeting face-to-face with the volunteers.

### 2.5. Data Collection Tools

The data of the study were collected by using the "Introductory Information Form" (10 questions) prepared by the researchers in line with the literature information and 24 questions, including "Parents' Views on Being with their Children during the resuscitation" [29].

There were questions about the sex, age, education level, employment status, health insurance, economic status, duration of marriage, number of children, whether the child has previously witnessed the resuscitation process, and whether there is a child they have lost before.

### 2.6. Form For Determining Parents' Views About Being With Their Children During Resuscitation

The form was designed, valid and reliable in 2019 by Yatkin A, Kokcu Dogan A and Kuguoglu S in accordance with self-report [28].

The items in the form were scored between 0-2 as follows no (0), not sure (1), yes (2). Answers within the

form were evaluated between 0-2. The form consisted of 7 sub-dimensions: procedural expectation, belief in the positive effect of being in the room, desire to be in the room, anxiety, decision making in the room, and seeking social support [29].

Total score is obtained by summing up all dimensions

### 2.7. Study Reliability

The form is a 3-point Likert-type form with each item scored between 0, 1, and 2. When the mean intervals of the responses were divided into equal parts ( $2/3 = 0.66$ ), it is evaluated as 0- .66 as low, .67-1.33 as medium and 0-1.34-2 as high level. General reliability of the form was internal cronbach alpha = .85.

Sub dimensions of the Alpha internal consistency coefficients of the sub-dimensions of the form; Procedural Expectation = .85, Belief in the Positive Effect of Being in the Room = .74, Desire to be in the Room = .79, Anxiety = .76, Decision Making in Room = .73, Seeking Social Support = .72, Witnessing = .79 [28].

### 2.8. Scope Validity and Pilot Study

For the content validity of the data collection forms, expert opinions were considered on the subject. Approximately 20 parents were pre-applied to determine whether the revised form was understood after being revised using expert opinions. Later, reorganizations were made on the form for questions that were not understood. The final form was applied by the researchers to the parents of the children in the neonatal and pediatric intensive care units within the scope of the research.

### 2.9. Statistical Analysis of Data

The data obtained in the study were analyzed using the licensed SPSS (Statistical Package for Social Sciences) for Windows 22.0 program. Number, percentage, average and standard deviation were used as descriptive statistical methods in the evaluation of the data. The t-test was used to compare quantitative continuous data between two independent groups, and the One-way Anova test was used to compare quantitative continuous data between more than two independent groups. Scheffe test was used as a complementary post-hoc analysis to determine the differences after the Anova test.

### 2.10. Limitations of the Research

The research is limited to parents who volunteer to participate in the inpatient study in neonatal and child intensive care units of a private university hospital in Istanbul, and the data is based on personal information.

### 2.11. Ethical Aspect of the Research

In order to conduct the research; with the approval of the ethics committee from the Istanbul Medipol University Non-Interventional Clinical Research Ethics Committee (10840098-604.01.01-E.8813 / 14.03.2018), a written permission was obtained from the chief physician of the private university hospital. Before collecting data, it was stated that they were free to participate in the research by giving information about the research to the "Volunteer Consent" and "Volunteering" principle, stating that they would be

free to participate in the research, stating that the information of the patients participating in the research will be kept confidential, and adhering to the principle of "Privacy and Protection of Confidentiality" The research was carried out without using the identity information of the participants.

### 2.12. Current Opportunities Used within the Study

The manager and staff authorized the neonatal and pediatric intensive care units of the private hospital to the researcher where research and data collection was carried out. However, no financial support was received from any institution or organization for research, and the researchers covered all financial expenses.

## 3. Results and Discussion

Overall findings were portrayed that 68% of the parents who participated in the research were women; 29.7% of them were in the 26-30 age range. It was determined that 33.3% of them had university or higher education. 61.3% of the parents in the sample group worked, and 88.3% had SGK (Health Insurance) assurance. It has been determined that 54.5% of them have medium or low economic status. 44.1% of the parents included in the study were married for 6 years or more; 38.3% of them had 1 child. It was determined that 93.7% did not witness the revival process beforehand. It was determined that 19.4% of the parents had previously lost children. It was determined that 85.6% of the sample group consisted of neonatal intensive care units and 14.4% consisted of parents whose children were in the pediatric intensive care unit.

Parents' opinions about being with their children during the resuscitation were recorded as follows "procedural expectation subgroup" mean  $10.51 \pm 2.40$  (Min = 3; Max = 12), "belief in the positive effect of being in the room" mean  $6.10 \pm 2.92$  (Min = 0; Max = 10), "subgroup of desire to be in the room" mean  $4.69 \pm 1.82$  (Min = 0; Max = 6), "anxiety subgroup" mean  $3.14 \pm 1.93$  (Min = 0; Max = 6), "Decision making in the room subgroup" mean  $2.37 \pm 1.73$  (Min = 0; Max = 6), "seeking social support subgroup" mean  $1.82 \pm 1.51$  (Min = 0; Max = 4), the average of "testify subgroup" was determined as  $.61 \pm 1.09$  (Min = 0; Max = 4) (Table 2).

When the "sex variable" and "desire to be in the room subgroup" scores of the parents in the sample group are compared; it was determined that the scores of women ( $4.52 \pm 1.94$ ) were lower than the scores of men ( $5.07 \pm 1.49$ ) and the difference between them was statistically significant ( $p = .02 < .05$ ) (Table 3).

There was a significant difference ( $p = .01 < .05$ ) between the educational status of parents who participated in the study and the desire to be in the room. The reason for the difference is that the scores of the students with education level of university and above ( $5.15 \pm 1.16$ ) are higher than the other group scores (Table 3). The difference between the "education status" variable of parents in the sample

**Table 1.** Descriptive Features of Parents (N = 222)

Identifying Characteristics	Groups	n	Percentage (%)
Sex	Women	151	68.0
	Male	71	32.0
Age	20-25 years	24	10.8
	<b>26-30 years</b>	<b>66</b>	<b>29.7</b>
	31-35 years	53	23.9
	36-40 years	39	17.6
	41 years and above	40	18.0
Education Status	Elementary	28	12.6
	Middle	48	21.6
	High school	72	32.4
	<b>University and above</b>	<b>74</b>	<b>33.3</b>
Work Status	Yes	136	61.3
	No	86	38.7
Health Insurance	<b>Social Security Insurance</b>	<b>196</b>	<b>88.3</b>
	Private Insurance	15	6.8
	None	11	5.0
Economic Status	<b>Middle and Lower</b>	<b>121</b>	<b>54.5</b>
	Good and Above	101	45.5
Marriage Duration	0-1 year	17	7.7
	2-3 years	65	29.3
	4-5 years	42	18.9
	<b>6 years and above</b>	<b>98</b>	<b>44.1</b>
Number of Children	<b>1</b>	<b>85</b>	<b>38.3</b>
	2	82	36.9
	3 and above	55	24.8
Prior Witness to Resuscitation	Yes	14	6.3
	<b>No</b>	<b>208</b>	<b>93.7</b>
Prior Passing of a Child	Yes	43	19.4
	<b>No</b>	<b>179</b>	<b>80.6</b>
Intensive Care Unit	<b>Neonatal ICU</b>	<b>190</b>	<b>85.6</b>
	Pediatric ICU	32	14.4

group and the “decision-making subgroup” scores were statistically significant ( $F = 2.92$ ;  $p = .035 < .05$ ). The difference is due to the fact that the scores of the students with education level of university and above ( $2.78 \pm 1.67$ ) were higher than other group scores (Table 3). The difference between the working status of the parents in the sample group and the procedural expectation sub-dimension was statistically significant ( $p = .00 < .05$ ).

**Table 2.** Parents Views on Being with Their Children During Resuscitation (N:222)

Sub Topics	Items	Avg±Ss	Min. - Max.	Form Range
Procedural Expectation	6	10.51±2.40	3-12	0-12
Belief in the Positive effects of being present in the room	5	6.10±2.92	0-10	0-10
The desire to be in the room	3	4.69±1.82	0-6	0-6
Doubt	3	3.14±1.93	0-6	0-6
Decision of Entering the room	3	2.37±1.73	0-6	0-6
Expecting Social Support	2	1.82±1.51	0-4	0-4
Witnessing	2	.61±1.09	0-4	0-4
<b>General Sum</b>	<b>24</b>	<b>28.24±6.64</b>	<b>12-44</b>	<b>48</b>

The procedural expectation scores of the employees ( $10.14 \pm 2.67$ ) were found lower than the procedural expectation scores ( $11.11 \pm 1.76$ ) of the unemployed (Table 3).

The difference between the economic status of the parents and the search for social support points is significant ( $p = .04 < .05$ ), and the social support seeking scores of those with medium and lower economic status ( $2.01 \pm 1.54$ ) are higher than the social support seeking scores of those with a good economic status (above). ( $1.59 \pm 1.46$ ) was high (Table 3).

The difference between the marriage duration and procedural expectation scores of the parents who participated in the study was found to be statistically significant ( $p = .02 < .05$ ). The procedural expectation scores ( $10.69 \pm 2.35$ ) of those with a marriage period of 6 years or more are higher than all other groups (Table 3).

The difference between the marriage duration and testimony scores of the parents who participated in the study was found significant ( $p = .01 < .05$ ). The reason for the difference lies in the fact that the testimony scores ( $.81 \pm 1.18$ ) of those with marriage duration of 6 years or more are higher than in other groups (Table 3).

A statistically significant difference ( $p = .02 < .05$ ) was found between the parents of the sample group who had previously witnessed the resuscitation process and the social support-seeking sub-dimension. Social support seeking points ( $2.71 \pm 1.27$ ) of those who previously witnessed the resuscitation were determined higher than the social support seeking points ( $1.76 \pm 1.51$ ) of those who did not witness the resuscitation (Table 3).

**Table 3.** The Comparison between the identity of the parents and their likelihood of witnessing resuscitation (N:222)

Demographic Characteristics		<i>n</i>	<i>Procedural Expectations</i>	<i>Positive aspects of bein present in the room</i>	<i>Desire to be present in the room</i>	<i>Doubt</i>	<i>Deciding whether to enter or not</i>	<i>Expecting Social Support</i>	<i>To be Witness</i>
			<i>Avg±SS</i>	<i>Avg±SS</i>	<i>Avg±SS</i>	<i>Avg±SS</i>	<i>Avg±SS</i>	<i>Avg±SS</i>	<i>Avg±SS</i>
<b>Sex</b>	Female	151	10.72±2.28	6.30±2.92	4.52±1.94	3.03±1.92	2.28±1.79	1.77±1.57	.54±1.06
	Male	71	10.07±2.60	5.68±2.94	5.07±1.49	3.35±1.94	2.55±1.60	1.93±1.40	.76±1.14
	<i>t=</i>		1.90	1.48	-2.13	-1.15	-1.09	-.74	-1.40
	<i>p=</i>		.06	.14	<b>.02</b>	.25	.28	.44	.16
<b>Ednaction Status</b>	Elementry	28	11.18±1.57	5.75±3.28	4.54±2.03	2.93±1.82	2.57±1.91	2.14±1.58	.71±1.12
	Middle	48	10.56±2.48	6.42±2.97	4.92±1.90	3.10±2.00	2.10±1.75	1.67±1.59	.73±1.23
	High School	72	10.65±2.50	6.13±2.85	4.14±2.11	2.94±1.89	2.03±1.64	1.54±1.45	.40±.83
	University and above	74	10.10±2.48	6.00±2.86	5.15±1.16	3.42±1.97	2.78±1.67	2.07±1.47	.70±1.18
	<i>F=</i>		1.57	.35	4.26	.88	2.92	2.09	1.34
	<i>p=</i>		.20	.79	<b>.00</b>	.45	<b>.04</b>	.10	.26
<i>PostHoc=</i>					2>3, 4>3 (p<0.05)		4>2, 4>3 (p<0.05)		
<b>Work Status</b>	Yes	136	10.14±2.67	5.86±2.97	4.75±1.73	3.27±2.02	2.40±1.68	1.68±1.45	.65±1.09
	No	86	11.11±1.76	6.48±2.82	4.61±1.97	2.93±1.78	2.31±1.82	2.04±1.59	.56±1.08
	<i>t=</i>		-2.97	-1.54	.58	1.26	.35	-1.69	.59
	<i>p=</i>		<b>.00</b>	.13	.56	.20	.73	.09	.55
<b>Economic Status</b>	Middle and Lower	121	10.70±2.14	6.01±3.05	4.82±1.66	3.00±1.89	2.18±1.65	2.01±1.54	.59±1.05
	Good and above	101	10.29±2.67	6.21±2.77	4.55±2.00	3.30±1.98	2.58±1.81	1.59±1.46	.64±1.13
	<i>t=</i>		1.29	-.51	1.12	-1.14	-1.73	2.04	-.39
	<i>p=</i>		.21	.61	.27	.26	.09	<b>.04</b>	.70
<b>Marriage Duration</b>	0-1	17	8.77±2.93	5.88±2.74	4.59±1.28	3.06±2.19	3.00±1.58	1.53±1.38	.53±1.23
	2-3	65	10.68±2.05	5.99±3.01	4.60±1.91	2.97±1.79	2.22±1.59	1.99±1.51	.26±.74
	4-5	42	10.55±2.61	5.64±2.96	4.48±1.99	3.62±1.86	2.21±1.80	1.69±1.52	.74±1.15
	6 years and over	98	10.69±2.35	6.41±2.89	4.87±1.77	3.05±2.00	2.42±1.82	1.82±1.55	.81±1.18
	<i>F=</i>		3.40	.77	.57	1.11	1.06	.56	3.65
	<i>p=</i>		<b>.02</b>	.51	.64	.35	.37	.64	<b>.01</b>
<i>PostHoc=</i>			2>1, 3>1, 4>1 (p<0.05)						3>2, 4>2 (p<0.05)
<b>Prior Witness to Resuscitatio n Process</b>	Yes	14	10.50±2.62	4.93±3.22	4.86±1.51	4.00±1.96	3.21±1.58	2.71±1.27	2.57±1.40
	No	208	10.51±2.39	6.18±2.90	4.68±1.84	3.08±1.92	2.31±1.73	1.76±1.51	.48±.93
	<i>t=</i>		-.02	-1.55	.35	1.74	1.91	2.31	7.88
	<i>p=</i>		.98	.12	.73	.08	.06	<b>.02</b>	<b>.00</b>
<b>Child which has passed</b>	Yes	43	10.79±2.25	5.98±3.15	5.21±1.15	2.86±2.08	2.26±1.56	1.98±1.66	.91±1.19
	No	179	10.45±2.44	6.13±2.88	4.57±1.93	3.20±1.89	2.39±1.78	1.78±1.48	.54±1.05
	<i>t=</i>		.84	-.31	2.08	-1.04	-.46	.76	1.99
	<i>p=</i>		.40	.76	<b>.01</b>	.30	.65	.45	.07
<b>Intensive Care Unit</b>	Neonatal ICU	190	10.47±2.36	5.77±2.92	4.80±1.79	3.24±1.84	2.36±1.76	1.96±1.46	.67±1.11
	Pediatric ICU	32	10.78±2.69	8.06±2.05	4.09±1.92	2.53±2.33	2.41±1.58	.97±1.58	.25±0.84
	<i>t=</i>		-.68	-4.26	2.03	1.92	-.15	3.52	2.06
	<i>p=</i>		.50	<b>.00</b>	<b>.04</b>	.11	.88	<b>.00</b>	<b>.02</b>

Anova

A statistically significant difference was found between the variable of "witnessing the resuscitation process" and the subscale sub-dimension scores of the parents ( $p = 0 < .05$ ). The scores of those who previously witnessed the animation ( $2.57 \pm 1.40$ ) were higher than those of the non-witnesses ( $.48 \pm .93$ ) (Table 3).

A significant difference ( $p = .01 < .05$ ) was found between the parents' losing their children and the sub-dimension of being in the room. The scores of those who previously lost their children ( $5.21 \pm 1.15$ ) were higher than those of those who did not lose ( $4.57 \pm 1.93$ ) (Table 3).

According to the research findings, a significant difference was found between the parents who had a child in the neonatal intensive care unit and the belief in the positive effect of being in the room ( $t = -4.26$ ;  $p = 0 < .05$ ). The belief scores ( $x = 5.77$ ) of the parents who had children in the neonatal intensive care unit were found to be lower than the belief scores ( $x = 8.06$ ) of the positive effect of the children in the pediatric intensive care unit (Table 3).

In the neonatal intensive care unit, a statistically significant difference was determined between the parents who had a child and the desire to be in the room ( $t = 2.03$ ;  $p = .04 < .05$ ). Parents with children in the neonatal intensive care unit were found to be higher in the room ( $x = 4.80$ ) than those who had children in the pediatric intensive care unit ( $x = 4.09$ ) (Table 3).

In the neonatal intensive care unit within the scope of the study, a statistically significant difference was found between the parents who had a child and the search for social support ( $t = 3.52$ ;  $p = .00 < .05$ ). Social support seeking scores of parents with children in the neonatal intensive care unit ( $x = 1.96$ ) were higher than those of children within the pediatric intensive care unit ( $x = .97$ ) (Table 3).

According to the findings of the study, a significant difference was found between the parents who were hospitalized in the neonatal intensive care unit and the testimony ( $t = 2.06$ ;  $p = .02 < .05$ ). The test scores of the parents who had children in the neonatal intensive care unit ( $x = .67$ ) were higher than the test scores of the parents in the pediatric intensive care unit ( $x = .25$ ) (Table 3).

According to the literature, families have some expectations and desires during the resuscitation process. Among these requests; to get accurate and complete information, to be physically and emotionally close to their children, to see that healthcare professionals are closely intervening with their child, to see their children frequently and to have information about the procedures performed. These show us that parents have expectations from healthcare professionals when they are in the room. These expectations can be met accurately and completely only by having written and regular procedures [1, 3, 6, 7, 9, 10, 11, 15, 19, 29]. Literature information is supported in our study.

The procedural expectation score of the parents who participated in the research was quite high. This shows that families want to be supported in accompanying the resuscitation. In Leung and Chow's study titled "Attitudes of healthcare staff and patients" family members towards family presence during resuscitation in adult critical care

units, published in the Journal of Clinical Nursing in 2012, the average score of the question group showing the procedural expectation of the families supports our study [18].

The general average of the belief section on the positive effect of parents in the room was found high in our study. This result shows that the parents who participated in the research think that being in the room has positive effects. In the literature, it is stated that families generally benefit from their children in the room, and they believe that the animation process is longer and more careful. In addition, they think they have benefits for themselves. Among them; to shorten the grieving process, say goodbye to their children [1-3, 10, 12, 13, 19, 20, 23-26].

In our study, the average score of the request to be in the room was found high.

In a similar study carried out by nursing students, it was determined that most of the students (89%) wanted to be with them during the painful procedures done to their relatives. In the article of Boztepe et al., published in the Journal of Nursing Education and Research in 2016, Examining the Views of Nursing Students on Patient Relatives and Parents' Presence of Patients During Painful Procedures and Cardiopulmonary Resuscitation. Psychological support (62.3%) ranks first among the reasons for wanting to be with relatives [5]. Our literature studies show that families mostly want to be in the room and have some expectations during this time [1, 3, 6, 7, 9, 10, 11, 15, 19, 29]. The results obtained in our study are in line with the literature information.

They abstained from the question about being in the room, which was within a question group about parents' anxiety resulting in anxiety within the environment. However, according to the results of the comparative study of O'Connell and friends, published in the American Journal of Critical Care in 2017, Family presence during trauma resuscitation: family members' attitudes, behaviors, and experiences, the families in the resuscitation room argued that their anxiety decreased (90%) when they were in the room. It was observed that family members who were not in the room thought that their anxiety would decrease by 52% [22]. This shows us that the people who experienced the event significantly reduced the level of anxiety. The people who did not experience the event are undecided on this matter. The results of our study are in line with the results of the research on this subject.

The average score of the decision-making question group in the room was found to be low. It has been observed that parents are reluctant about whether they are asked in the room and who decides. This situation is thought to be due to the lack of implementation and procedures on the subject.

Testing subgroup average score and positive answers to the questions in this group have resulted in very low results. In our country, this subject has begun to be researched. However, there are still no written and standard procedures set out. For this reason, it can be thought that the scores of the participants to witness and demand are low.

When parents' views about resuscitation are compared with descriptive features; there was a significant difference

between the desire to be in the room between men and women ( $p < .05$ ). The average score of men is higher than that of women. These results are thought to be a result of the fact that women have a more emotional structure than men and that they may have difficulty in enduring the attempts.

Considering the working situation, it was determined that the non-working parent group had more expectations procedurally ( $p < .05$ ). Most of the individuals who participated in our study and did not work were women, and the burden of childcare is placed on the unemployed mother, although both parents are responsible. Considering that the mother in charge of care is more interested in the health and hospital processes of the child, it is thought that she has more expectations from the healthcare team.

Social support scores of those who witnessed the resuscitation process were found to be significantly different ( $p < .05$ ). This situation, which has started to be accepted in the world, is newer for our country and unfortunately there are no written standard procedures. In addition, health professionals do not have training on this matter. Considering these situations, the resuscitation attempt they witnessed can be expected to have a traumatic effect on individuals. However, despite these results, the average of testifying points was still higher than the families who did not testify ( $p < .05$ ). This shows us that they want to support their children in every way and condition possible.

According to the results of our study, the wishes of individuals who lost their children before were seeking to be in the room were found to be statistically significant ( $p < .05$ ). According to the literature, parents who are allowed to be in the room feel that they support their children, have goodbye opportunities and think that they do their best for their children [1-3, 10, 12, 13, 19, 20, 23-26]. Therefore, it can be expected that people who have experienced this loss and could not be with their child have high expectations.

#### 4. Conclusion

In this study, which was conducted to determine the views of parents about being with their children during the resuscitation, the following results were obtained.

It was determined that the majority of the participants were female, 20-25 years old, university graduates, worked, had social security, expressed their economic status as middle and lower, and married for 6 years and over.

Parents child rates were as follows; 38.3% of the parents in the study group had 1 child, 36.9% had 2 children, 24.8% had 3 or more children, 93.7% had not witnessed the resuscitation process before, It was determined that 80.6% of whom who had never lost a child, 85.6% of whom had a child in the neonatal intensive care unit.

*In line with the results we obtained in our study, the following suggestions were proposed.*

Health protocols and procedures should be established more comprehensively and implemented in all health institutions that provide resuscitation services. The entire healthcare team working in intensive care units and emergency rooms should be thoroughly trained in this regard.

A separate group of staff, whose sole task is to take care of the family and to take necessary action when the family deteriorates, should be included in all health institutions, and this staff should be given special training in approach to the family.

Family support staff is the person who supports the family during difficulties experienced by the family, in moments of stress during resuscitation and when they encounter unexpected events. There is no direct patient care responsibility. It is appointed only to help the family. The social counselor trained in this area may be a civil servant or a nurse can give information about the procedures of the initiatives. However, staff should be careful about stating the indications and results of the procedures performed, and let the physician explain the process afterwards [8, 11]. Families who have children in intensive care should be informed about this issue in the early period and the resuscitation team should evaluate their demands and expectations. The decision to take the family to the room should be made by the whole team, under the leadership of the family support staff. Standards should be determined for the parents' acceptance into the room and the family should be evaluated within the framework of these standards.

A security guard and psychologist should be kept in the resuscitation room to monitor the family from a distance. The family should be trained by the family support staff before they are taken into the room, and they should give them confidence that their children's life is paramount.

The attempts made during the resuscitation should be explained to the family in a correct and understandable way.

When the family deteriorates, the family support staff should have the ability to intervene.

When the child is at a loss, the family should be encouraged to touch and say goodbye while the body is still warm, and the family should be left alone with the child.

Post-resuscitation procedures should be developed and implemented. Clergymen should be present at the request of the family. Nurses should be trained on family approach. After the resuscitation procedure, the physician should talk to the family and provide detailed information. If the child is alive, possible complications should be reported to the family.

Research on the subject should be supported and encouraged.

#### 5. Acknowledgements and Disclosures

The authors declare that there are no conflict of interests. B.Y., A.K.D., S.K. contributed equally for conceptualized and designed the study. Data were collected by B.Y.

#### References

1. Al-Mutair, A, Plummer, V, Copnell, B, Family presence during resuscitation: a descriptive study of nurses' attitudes from two Saudi hospitals, *British Association of Critical Care Nurses*, 2012, 17(2), 90-98.
2. Badir, A, Sepit, D, Family presence during CPR: A study of the experiences and opinions of Turkish critical care nurses, *International Journal of Nursing Studies*, 2007, 44, 83-92.
3. Basol, R, Ohman, K, Simones, J, Skillings, K, Using research to determine support for a policy on family presence during



- resuscitation, *Dimensions of Critical Care Nursing*, 2009, 28(5), 227-247.
4. Boudreaux, E, Francis, J, Loyacano, T, Family presence during invasive procedures and resuscitations in the emergency department: a critical review and suggestions for future research, *Annals Of Emergency Medicine*, 2002, 40(2), 193-205.
  5. Boztepe, H, Çınar, S, Ertug, N, Hemsirelik Öğrencilerinin Hasta Yakınları ve Ebeveynlerin Ağrılı İşlemler ve Kardiyopulmoner Resüsitasyon Sırasında Hastanın Yanında Bulunmalarına İlişkin Görüşlerinin İncelenmesi, *Hemşirelikte Eğitim ve Araştırma Dergisi*, 2016, 13(3): 264-271 doi:10.5222/HEAD.2016.264.
  6. Chapman, R, Watkins, R, Bushby, A, Assessing health professionals' perceptions of family presence during resuscitation: A replication study, *International Emergency Nursing*, 2015, 21, 17-25.
  7. DeWitt, S, Should Family-Witnessed Resuscitation Become Our Standard? *The Journal of Emergency Medicine*, 2015, 49, 500–502.
  8. Emergency Nursing Association, Clinical practice guideline: family presence during invasive procedures and resuscitation, 2012.
  9. Ersoy, G, Yanturalı, S, Family witness resuscitation. Allow or deny? Which is true? *International Journal of Nursing Studies*, 2006, 43, 653–654.
  10. Farah, M, Thomas, C, Shaw, K, Evidence-based guidelines for family presence in the resuscitation room a step-by-step approach, *Pediatric Emergency Care*, 2007, 23(8), 587-591.
  11. Fernandez, R, Compton, S, Jones, K, Velilla, M, The presence of a family witness impacts physician performance during simulated medical codes, *Critical Care Medicine*, 2009, 6, 1956-1960.
  12. Günes, U, Zaybak, A, A study of Turkish critical care nurses' perspectives regarding family-witnessed resuscitation, *Journal of Clinical Nursing*, 2009, 18, 2907-2915.
  13. Hassankhani, H, Zamanzade, V, Rahmani, A, Haririan, H, Family support liaison in the witnessed resuscitation: A phenomenology study, *International Journal of Nursing Studies*, 2017, 74, 95-100.
  14. Hodge, A, Marshall, A, Family presence during resuscitation and invasive procedures, *Collegian*, 2009, 16, 101-118.
  15. Holzhauser, K, Finucane, J, Vries, S Family presence during resuscitation: a randomised controlled trial of the impact of family presence, *Australasian Emergency Nursing Journal*, 2006, 8(4), 139-147.
  16. Jabre, P, Belpomme, V, Azoulay, E, Jacob, L, Bertrand, L, Lapostolle, et al., Family presence during cardiopulmonary resuscitation, *The New England Journal of Medicine*, 2013, 368(11), 1008-1018.
  17. Kingsnorth, J, O'Connell, K, Guzzetta, C, Edens, J, Atabaki, S, Mecherikunnel, et al., Family presence during trauma activations and medical resuscitations in a pediatric emergency department: an evidence-based practice Project, *Journal Of Emergency Nursing*, 2010, 36, 115-121.
  18. Leung, N, Chow, S, Attitudes of healthcare staff and patients' family members towards family presence during resuscitation in adult critical care units, *Journal of Clinical Nursing*, 2012, 21, 2083-2093.
  19. Mangurten, J, Scott, S, Guzzetta, C, Clark, A, Vinson, L, Sperry, J, Hicks, B, Voelmeck, W, Effects of family presence during resuscitation and invasive procedures in a pediatric emergency department, *Journal Of Emergency Nursing*, 2006, 32, 225-233.
  20. McClenathan, B, Torrington, K, Uyehara, C, Family member presence during cardiopulmonary resuscitation a survey of us and international critical care professionals, *Chest*, 2002, 122, 2204-2211.
  21. McGahey, P, Family presence during pediatric resuscitation: a focus on staff, *Critical Care Nurse*, 2002, 22(6), 29-34.
  22. O'Connell, K, Fritzeem, J, Guzzett, C, Clark, A, Lloyd, C, Scott, S, Aldridge, M, Kreling, B, Family presence during trauma resuscitation: family members' attitudes, behaviors, and experiences, *American Journal Of Critical Care*, 2017, 26(3), 229-239.
  23. Parial, L, Torres, G, Mcindo, J, Family presence during resuscitation benefits-risks scale (fpdr-brs): Instrument development and psychometric validation, *Journal Of Emergency Nursing*, 2016, 42, 213-223.
  24. Porter, J, Cooper, S, Sellick, K, Attitudes, implementation and practice of family presence during resuscitation (FPDR): A

- quantitative literature review, *International Emergency Nursing*, 2013, 21, 26-34.
25. Robertis, E, Romano, G, Hinkelbein, J, Piazza, O, Sorriento, G, Family presence during resuscitation: A concise narrative review, *Trends in Anaesthesia and Critical Care*, 2017, 1-5.
  26. Sherman, D, Family presence during cardiopulmonary resuscitation, *Dimensions of Critical Care Nursing*, 2008, 27(3), 114-117.
  27. Vavarouta, A, Xanthos, T, Papadimitriou, L, Kouskouni, E, Lacovidou, N, Family presence during resuscitation and invasive procedures: Physicians' and nurses' attitudes working in pediatric departments in Greece, *Resuscitation*, 2011, 82, 713–716.
  28. Yatkın, B, Kokcu Dogan, A, Kuguoglu, S, The parents' views related to be together with their Children during the resuscitation: scale development Study and the sample on intensive care unit, Istanbul Medipol University, Institute of Health Sciences, Master Thesis, Istanbul, 2019.
  29. Zali, M, Hassankhani, H, Powers, K, Dadashzadeh, A, Ghafouri, R Family presence during resuscitation: A descriptive study with Iranian nurses and patients' family members, *International Emergency Nursing*, 2017, 34, 11-16.

<http://edergi.cbu.edu.tr/ojs/index.php/cbusbed> isimli yazarın CBU-SBED başlıklı eseri bu Creative Commons Atıf-Gayriticari4.0 Uluslararası Lisansı ile lisanslanmıştır.

