

# Family presence in the resuscitation room: evidence?

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Nothing to disclose



# History





# Birth and delivery: Timeline

Birth and delivery → female relatives and friends with midwife

1760 doctors started to deliver upper class women



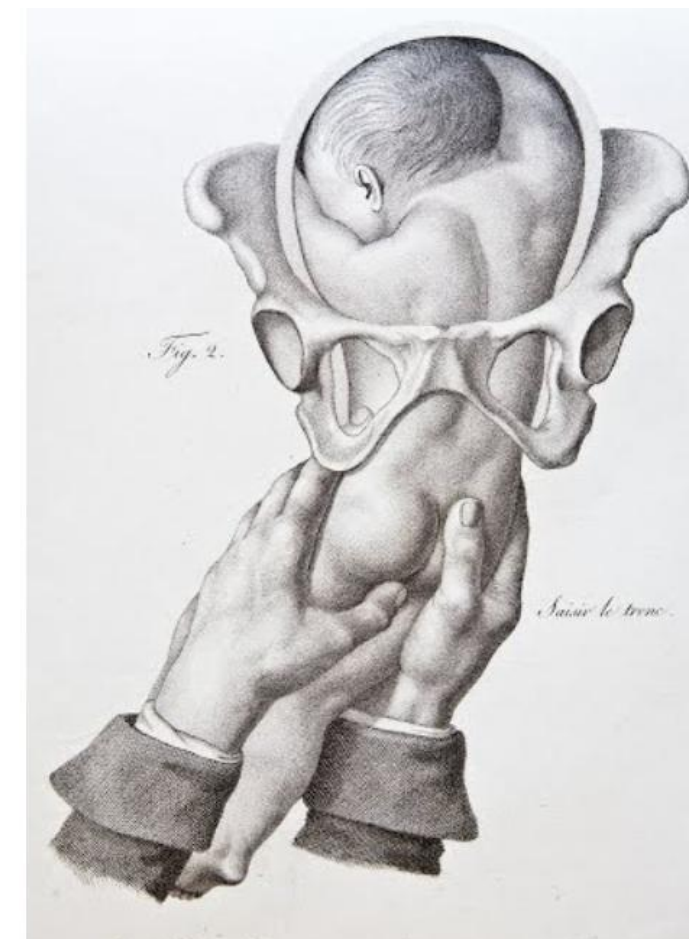
But baby and mothers died...  
It was a scary experience



1900 hospital for « pain free delivery », but still not safe

# Medicalisation of delivery

- Baby-mother separation to « improve outcome »
- Separation
- Bonding issues/delays
- PTSD



RESEARCH

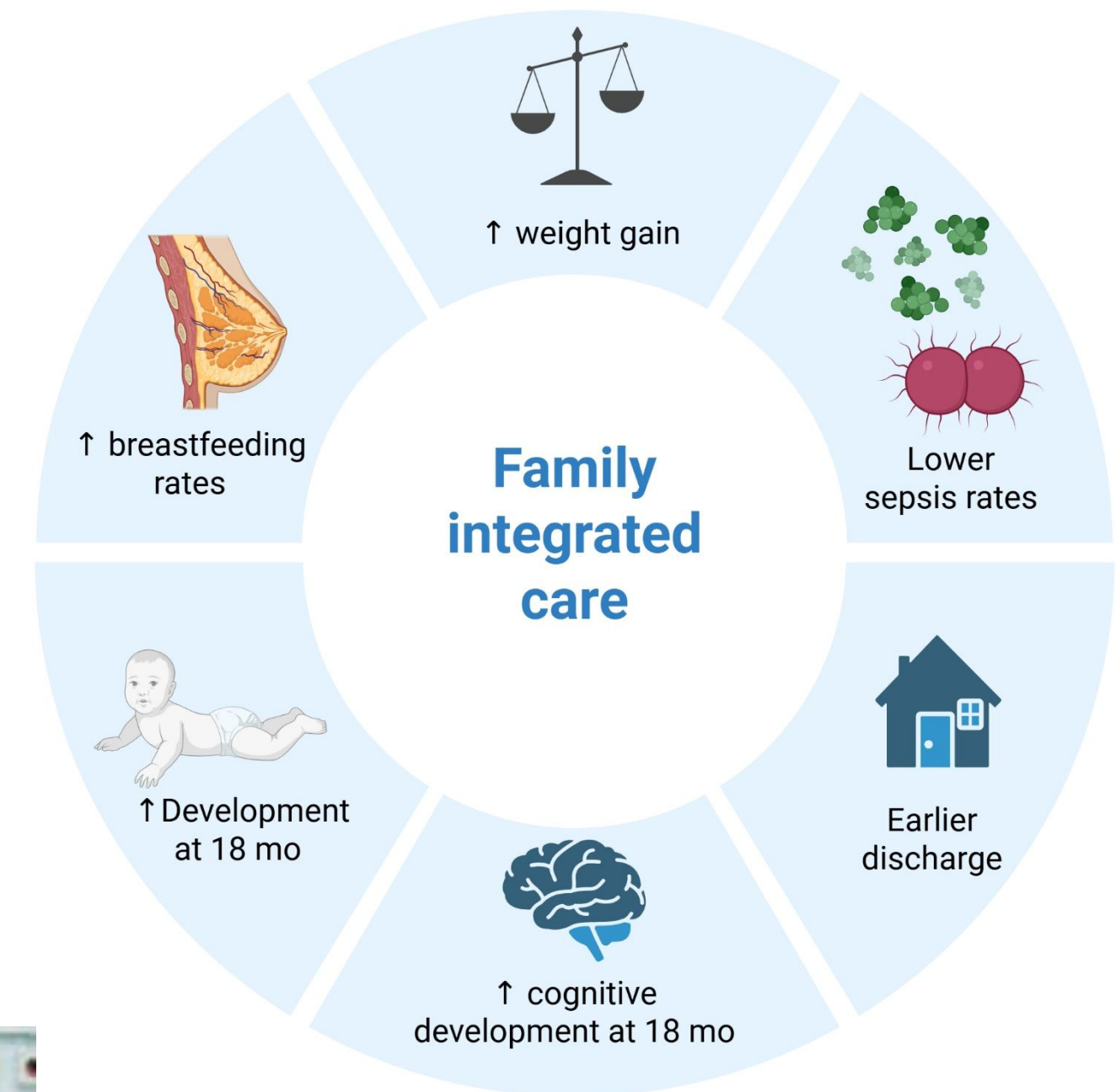
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# Neonatal outcomes from a quasi-experimental clinical trial of Family Integrated Care versus Family-Centered Care for preterm infants in U.S. NICUs

Linda S. Franck<sup>1\*</sup>, Caryl L. Gay<sup>1</sup>, Thomas J. Hoffmann<sup>2</sup>, Rebecca M. Kriz<sup>1</sup>, Robin Bisgaard<sup>3</sup>, Diana M. Cormier<sup>4</sup>, Priscilla Joe<sup>5</sup>, Brittany Lothe<sup>6</sup> and Yao Sun<sup>7</sup>

- Gradual inclusion of parents in NICUs
- Family integrated care
- Neonatal outcomes improvement



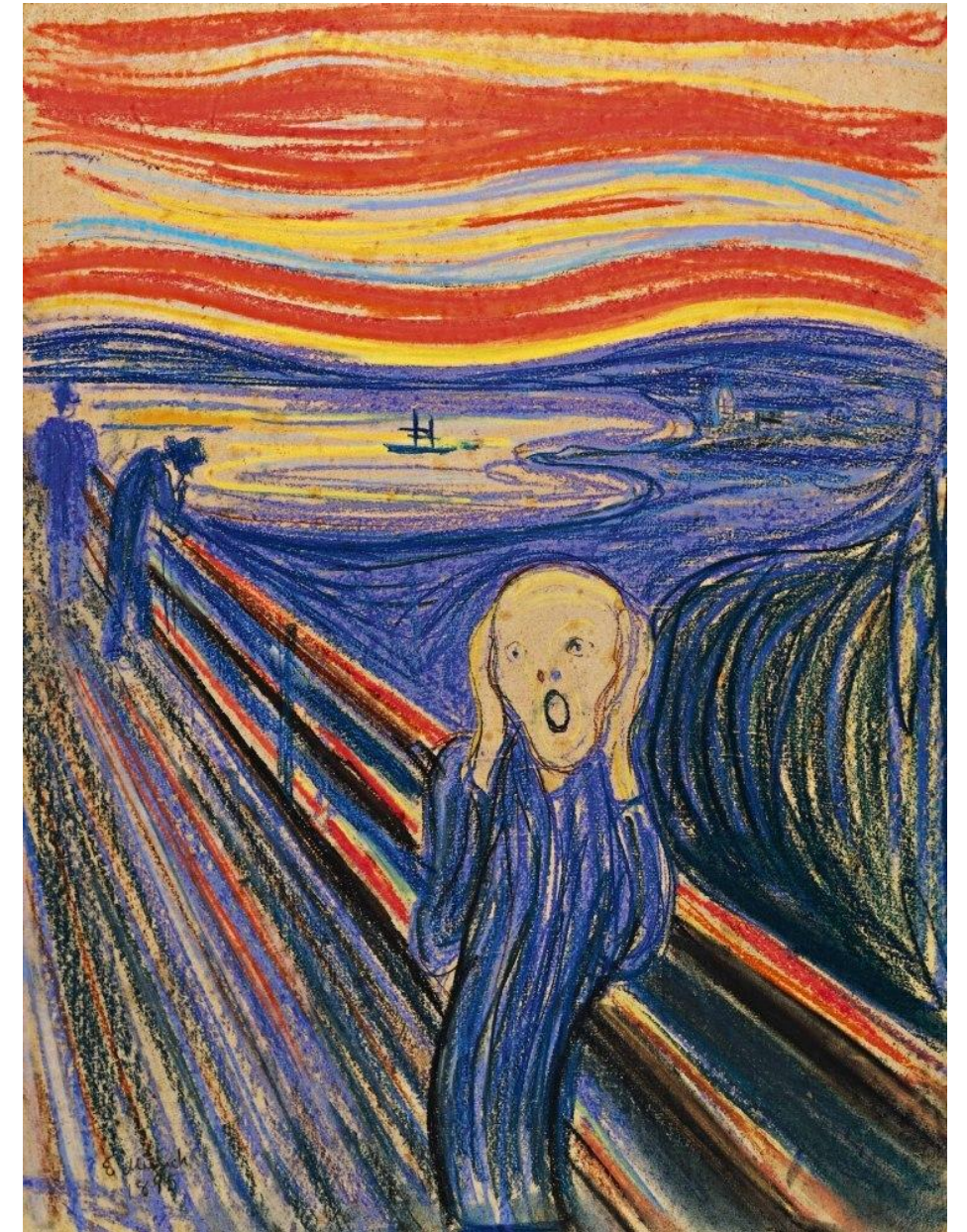


# But...

↑ family presence



↑ presence in critical situations



# What is already known?

- Adults
- Pediatrics
- Critical situations in NICU → literature is scarce
- In delivery room → even scarcer



# Family presence during resuscitation

- Implemented in adults since 1987 and then in pediatric population
- Recommended by European and American societies
- Benefits are clear:
- ↓ PTSD, anxiety and depression in families, even in case of adverse outcome
- ↓ legal litigations



# Healthcare workers

- Still reluctant
- Fear decrease quality of resuscitation
- Feel unprepared and untrained
- Increase stress
- Deal with own and parents' emotions and reactions
- One person must be in charge of the family



Vavarouta, A., et al. 2011.

Harvey, M. E. & Pattison, H. M. 2013

# SUPPORT OF ADAPTATION AND RESUSCITATION OF THE NEWBORN INFANT

Revised Recommendations of the Swiss Society of Neonatology (2023)

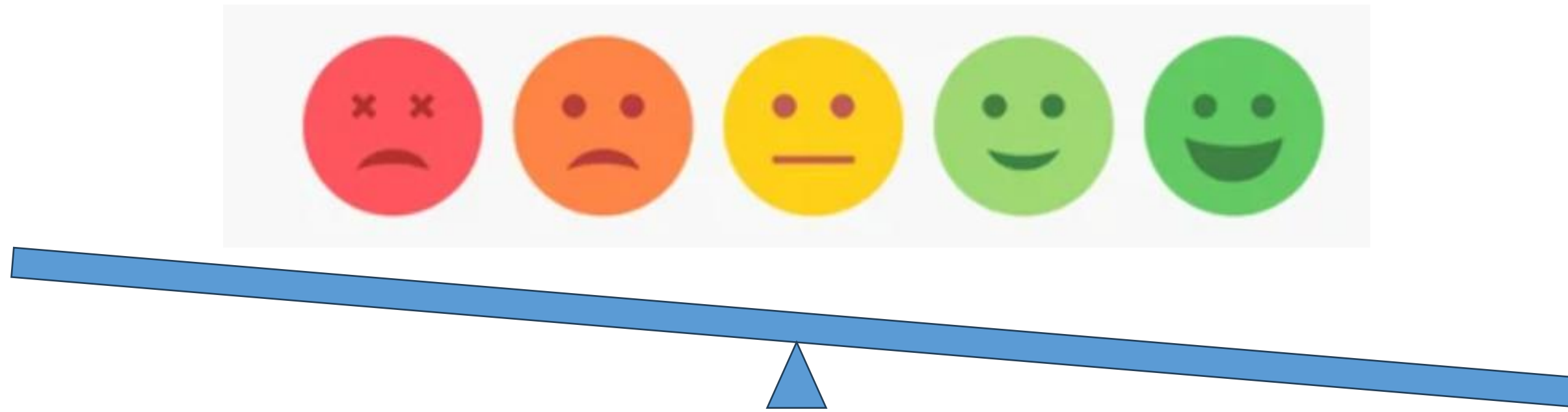
Elaborated by a working group of the Swiss Society of Neonatology consisting of (in alphabetical order):

Berger T.M., Basel;  
Fauchère J-C., Zurich;  
Kothari R., Lucerne;  
Held-Egli K., Bern;  
El Faleh I., Neuchâtel;  
Melchior S., Lausanne;  
Muehlethaler V., Delémont;  
Pfister R.E., Geneva;  
Schuler-Barazzoni M., Lausanne;  
Ragazzi M., Bellinzona;  
Schulzke S., Basel;  
Steiner A. (Swiss Federation of Midwives), Bern;  
Willi B., Chur

- Caring for parents during the delivery → crucial
  - Difficult adaptation
  - Malformations
- } More demanding
- Offer resuscitation in the delivery room if possible
  - More stress and distraction for the team
  - Team must feel comfortable
  - Team leader decision to allow parents or not







- Parents experiences are different
- Adequate communication necessary whether they are inside the resuscitation room or not
- A person should be in charge of the parent

## **Family presence during resuscitation in paediatric and neonatal cardiac arrest: A systematic review**

- Systematic and comprehensive review
- 141 articles (1999-2019)
- 21 countries
- In children with cardiac arrest, does family presence during resuscitation vs no family presence result in improved outcomes (for patient, family and HCP)?

# Delivery room

- Very different type of studies
- Father → unique experience
- Parents felt their presence provided
  - Reassurance
  - Involvement
  - Communication
- Need for staff training and debriefing
- 1st contact with baby → polarized emotions

But also  
emotional toll





# Limitations

- High variability in methodological methods and rigor
  - High risk of bias
    - HCP experience not reported
    - Volunteer bias
    - Low response rates
    - Use of investigator derived one-time surveys (not validated)
  - « Family presence » encompasses more than clinical outcomes
- Many factors difficult to measure

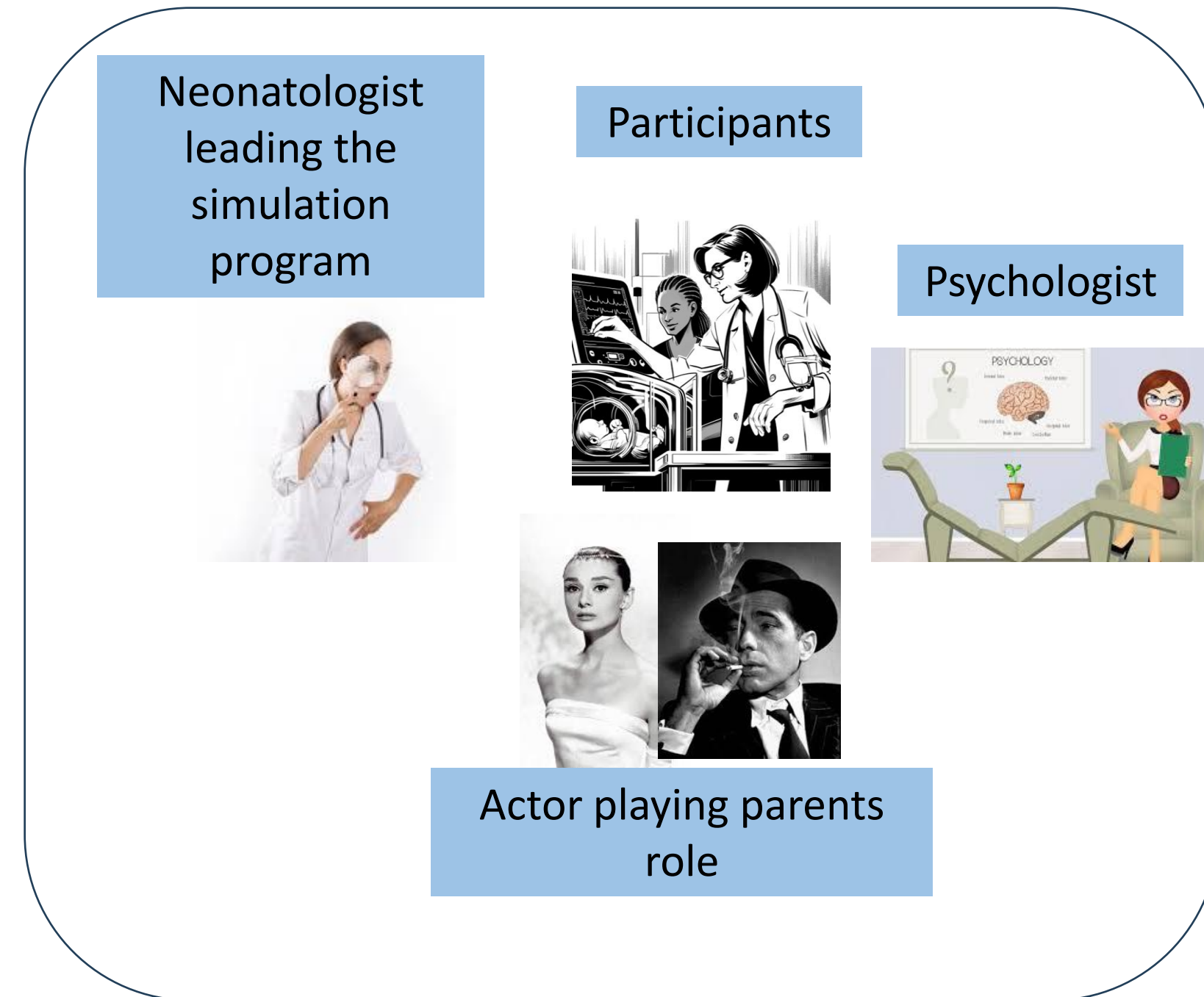
# Dainty et al.' s conclusions

- No evidence to improve any patient or family outcome
- Parents wish to have the choice to be present
- HCP remain divided about opinion on family presence
- Education and training are needed (staff and parents opinion)
- **Overall very low quality of evidence**
- RCT might not be ethically possible
- High quality comparative research needed

# Our experience in Geneva



- Educational video
- Simulation with parents (actors)
- Simulation conflict situations



- Defusing
- Familypresence in delivery room

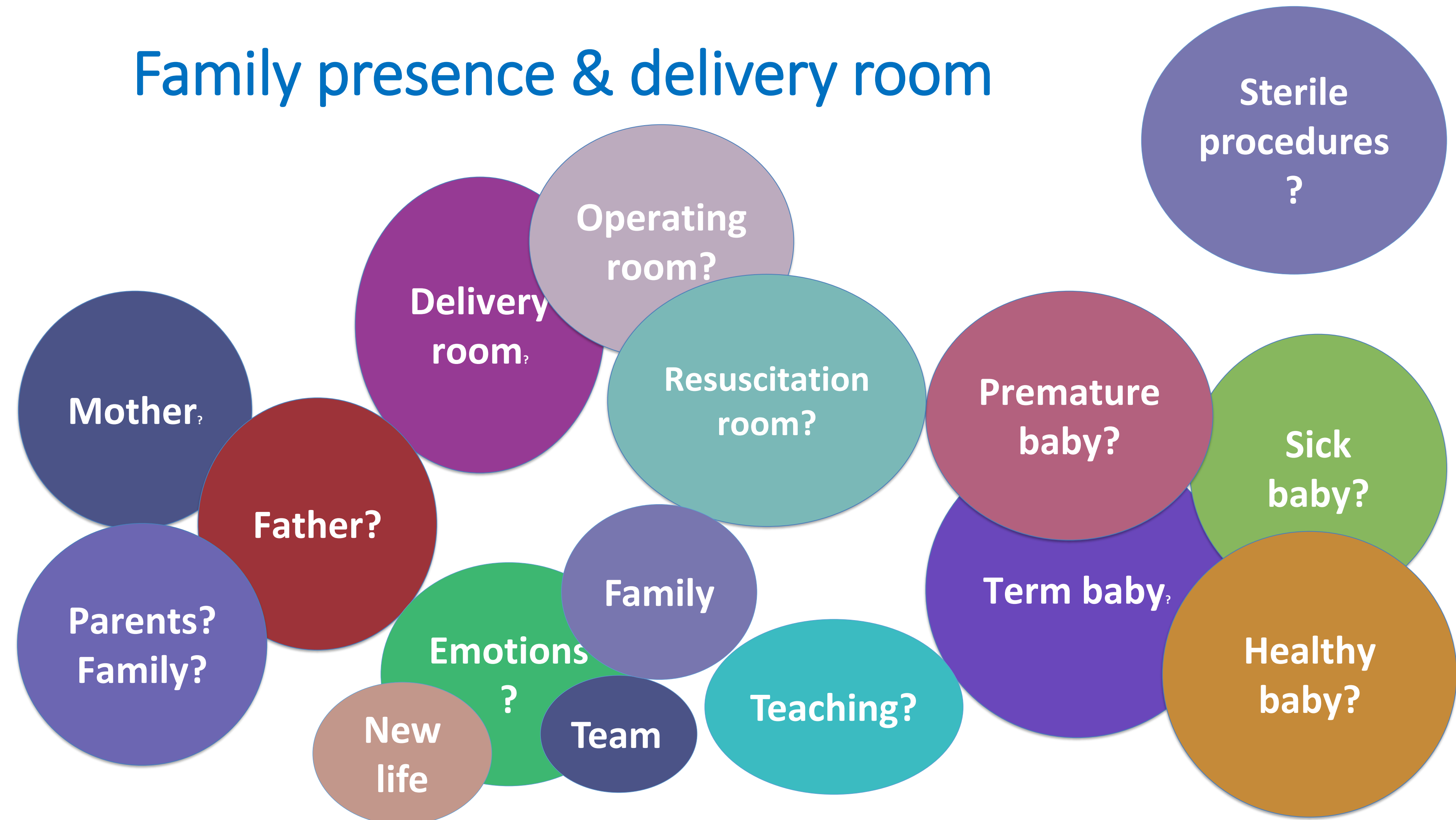
not yet implemented



# What we have learned

- Education is important even for non technical skills
- Training is mandatory
- Simulation is useful and allows continous training
- A person in charge of the parents is essential

# Family presence & delivery room



# Resuscitation in delivery room





# The question is not if we should do it... rather

- How
- In which cases
- Which goal
- Which focus
- With which means

# Open questions

- Are we doing « too much »?
- Is it positive to be present in case of unsuccessful resuscitation after the delivery?

...(we know it is in pediatrics...but factors linked to delivery and birth remain unexplored)

- What outcomes and indicators should we explore to evaluate if it is positive or not?

Please share your opinion!



**Thank you  
for your attention!**

