POSITION STATEMENT

Nursing Care and Do-not-resuscitate (DNR) Decisions

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Written by: ANA Center for Ethics and Human Rights
Adopted by: ANA Board of Directors

Purpose

The nurse's role includes assisting patients, families, surrogate decision-makers, and health care team members in the process of making informed choices regarding do-not-resuscitate orders. It is important to note that considerations for do-not-resuscitate orders can happen at any time in the course of a patient's care, not only at the end of life. Practice guidelines exist regarding effective cardiopulmonary resuscitation. Performing resuscitation that is inconsistent with this evidence-informed practice risks challenges to professional integrity as well as potential harm to patients. In addition, there still exists confusion regarding do-not-resuscitate orders and related terminology. This statement provides ethical guidance for nurses in the do-not-resuscitate decision-making process and makes recommendations for clinical and policy change.

Statement of ANA Position

Nurses advocate for and play an active role in initiating discussions about resuscitation with patients, families, and members of the health care team. Care for patients with do-not-resuscitate orders is no different from care for any other patient, including respect and advocacy for the patients' preferences and values, promotion of well-being, and alleviation of suffering. Patients with do-not-resuscitate orders must not be abandoned, nor should these orders lead to any diminishment in quality of care. Nurses' holistic view of patient and family care prepares them to collaborate with the patient, family, and health care team to promote informed decisions when do-not-resuscitate decisions are made.

History/Previous Position Statements

ANA adopted a position statement titled *Nursing Care and Do-Not-Resuscitate Orders* in 2003. This statement was preceded in 1991 by the position statement Promotion of Comfort and Relief of Pain in Dying Patients, which indirectly addressed do-not-resuscitate concerns. The 2012 revised ANA position statement was titled Nursing Care and Do-Not-Resuscitate and Allow Natural Death Decisions. This statement reflected the complexity of the do-not-resuscitate practice and introduced alternative language emerging at the time, such as "allow natural death," regarding end-of-life decisions.

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Code of Ethics for Nurses with Interpretive Statements

The following sections from the Code of Ethics for Nurses (2015) serve as support for this position statement.

Provision 1.2

- Nurses establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice. When planning patient, family and population centered care, factors such as lifestyle, culture, value system, religious or spiritual beliefs, social support system, and primary language shall be considered. Such considerations must promote health, address problems, and respect patient decisions. This respect for patient decisions does not require that the nurse agree with or support all patient choices. (p. 1)

Provision 1.3

- Nurses are leaders who actively participate in assuring the responsible and appropriate use of interventions in order to optimize the health and well-being of those in their care. This includes acting to minimize unwarranted, unwanted, or unnecessary medical treatment and patient suffering. Such treatment must be avoided, and conversations about advance care plans throughout multiple clinical encounters helps to make this possible. Nurses are leaders who collaborate in altering systemic structures that have a negative influence on individual and community health. (p. 2)

Provision 1.4

- Respect for human dignity requires the recognition of specific patient rights, in particular the right to self-determination. Patients have the moral and legal right to determine what will be done with and to their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed decision; and to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment. They also have the right to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or prejudice, and to be given necessary support throughout the decision-making and treatment process (p. 2). [Further], the importance of carefully considered decisions regarding resuscitation decisions, withholding and withdrawing life-sustaining therapies, forgoing nutrition and hydration, palliative care, and advance directives is widely recognized. Nurses assist patients as necessary with these decisions. Nurses should promote advance care planning conversations and must be knowledgeable about the benefits and limitations of various advance directive documents. (p. 3)

Provision 2.3

- Collaboration intrinsically requires mutual trust, recognition, respect, transparency, shared decision-making, and open communication among all who share concern and responsibility for health outcomes. Nurses assure that all relevant persons, as moral agents, are participatory in patient care decisions. Patients do not always know what questions to ask. Nurses assure informed decision-making by assisting patients to secure the information that they need to make choices consistent with their own values. (p. 6)

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Ethical Nursing Practice and Complexity in the Care of Patients with Do-not-resuscitate Orders

Confusion about terms/concepts related to do-not-resuscitate

Language matters in promoting effective communication with patients, family members, and others. Both health care providers and the public can be confused about the definition and implications of DNR (do not resuscitate) and associated terms such as comfort care, DNAR (do not attempt resuscitation), DNI (do not intubate), FC (full code), and POLST (Physician's Orders for Life Sustaining Treatment) (Jordan, Elliott, Wall, Saul & Sheth, et al., 2016; Pirinea, Simunich, Wehner & Ashurst, 2016). Multiple factors affect resuscitation preferences, including decline in clinical condition, multimorbidity, family involvement, and palliative care consultation (Dunlay, Swetz, Redfield, Mueller & Roger, 2014; Sudore, Casarett, Smith, Richardson & Ersek, 2014; Fosler, Staffileno, Fogg & O'Mahoney, 2015). Improvement in education is needed to assist patients and families in learning about, understanding, and shaping these decisions (Bardach, Dunn & Stein, 2017; Jordan, et al., 2016; Miller, 2018).

More than a decade ago, attempts were made to clarify terminology by using "allow natural death" to replace "do not resuscitate" (Knox & Vereb, 2005). An early study of registered nurses, nursing students, and a small control group of non-nurses (Venneman, Narnor-Harris, Perish & Hamilton, 2008) indicated that participants had a higher level of acceptance of the term Allow Natural Death when compared to Do Not Resuscitate (Venneman, Narnor-Harris, Perish & Hamilton, 2008). However, there was no significant difference found in a more recent study of advanced cancer patients in acceptability between the terms (Milijkovic, Emuron, Rhodes, Abraham & Miller, 2015). The use of the term Allow Natural Death has no firm basis in evidence and does not compellingly contribute to clarity of terminology.

A number of organizations recommend discouraging or eliminating the use of acronyms and abbreviations to reduce the risk of miscommunication (AORN, 2014; The Joint Commission, 2018; CMS Medicare Requirements, 2018). Using terminology that is explanatory, clear, and helpful to patients and family can still be difficult. Ethical nursing practice requires fluency with terminology related to resuscitation and the capacity to support patient decisions in ways that are consistent with patient preferences and values.

Current evidence surrounding resuscitation

To promote and provide ethical care for their patients, nurses must be familiar with current data regarding resuscitation outcomes. While rates of survival to discharge and neurologic outcomes following in-hospital resuscitation have improved in recent years, it is important to support patients and families in understanding the unique bearing a particular patient's clinical status has on resuscitation efficacy (Girotra, Nallamothu, Spertus, Li, Krumholz & Chan, 2012). For example, comorbidities, cardiac rhythm at the time of arrest, etiology of cardiac arrest, and patient location at the time the patient requires in-hospital resuscitation are important factors impacting resuscitation outcomes (Kayser, Ornato & Peberdy, 2008; Mhyre, Ramachandran, Kheterpal, Morris & Chan, 2010; Meaney, Bobrow, Mancini, et al., 2013). Out-of-hospital resuscitation outcomes have also improved but are similarly impacted by risk factors and timing of arrest (Meaney, Bobrow, Mancini, et al., 2013; Michelson, Hudgins, Monuteaux, Bachur & Finkelstein, 2018). Nurses support patients, families, and health care teams by incorporating specific clinical factors into discussions about resuscitation, including how those may inform the consideration of benefits, burdens, and risks of resuscitation for a particular patient and whether do-not-resuscitate orders are aligned with a patient's preferences, values, and goals of care. Nurses advocate for communication about code status preferences among all involved parties and anticipate the need for written do-not-resuscitate orders, including the benefit/burden/risk details of resuscitation discussions, before decompensation or an arrest occurs.

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Considerations of patients in surgery

Care of patients with do-not-resuscitate orders sometimes includes surgery for curative or palliative interventions. The Association of periOperative Registered Nurses (AORN) position statement on perioperative care of patients with do-not-resuscitate or allow-natural-death orders (2014) purports that reconsideration of do-not-resuscitate orders is required and is an integral component of the care of patients undergoing surgery or other invasive procedures. The AORN position statement also asserts that health care providers should have a discussion with the patient or patient's surrogate about the risks, benefits, implications, and potential outcomes of anesthesia and surgery in relation to the do-not-resuscitate orders before initiating anesthesia, surgery, or other invasive procedures.

The American Academy of Pediatrics (Fallat & Hardy, 2018) recommends utilizing a reevaluation process, also called "required reconsideration," which can be incorporated into the process of informed consent for surgery and anesthesia. This is also supported by the American College of Surgeons position statement Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room, which asserts that policies that lead either to the automatic enforcement of all do-not-resuscitate orders or to disregarding or automatically canceling such orders do not sufficiently support a patient's right to self-determination. When such patients who have do-not-resuscitate orders in place undergo surgical procedures and the accompanying sedation or anesthesia, they are subjected to new and potentially correctable risks of cardiopulmonary arrest; many of the therapeutic actions employed in resuscitation (for example, intubation, mechanical ventilation, and administration of vasoactive drugs) are also an integral part of routine anesthesia management, and it is appropriate that patients be so informed (ACS, 2014).

Advocacy, policies, and guidelines

Nurses are encouraged to take an active role in developing do-not-resuscitate policies within the institutions where they work. In health care organizations, do-not-resuscitate policies should be in place and enable nurses to effectively participate in this crucial aspect of patient care. As primary, continuous health care professionals, nurses have a key role in the planning as well as the implementation of resuscitation decisions. Nurses recognize that the resuscitation refusal by the patient with decision-making capacity should be given highest priority, even when these wishes conflict with those of the health care team and/or family. Nurses also advocate for collaboration with the health care team when dealing with do-not-resuscitate related issues and decisions. "To function effectively, nurses must be knowledgeable about ANA's *Code of Ethics for Nurses with Interpretive Statements*; standards of practice for the profession; relevant federal, state and local laws and regulations; and the employing organization's policies and procedures" (ANA, 2015b, p. 12).

Nurses advocate for hospital do-not-resuscitate policies to reflect understanding that cardiopulmonary resuscitation comprises a series of evidence-based interventions employed in sequence in the context of cardiopulmonary decompensation or arrest. As a result, nurses advocate for do-not-resuscitate policies that discourage "slow codes" or partial codes, which are inconsistent with evidence-based practice. ". . . (P)artial attempts to reverse a cardiac or pulmonary arrest are medically unsound because these interventions are often highly traumatic and consistently inefficacious" (Berger, 2003, p. 2,271). Such resuscitation risks violating the ethical obligation of nonmaleficence.

Finally, nurses advocate for hospital policies to recognize that circumstances may arise when do-not-resuscitate decisions pose ethical conflicts and/or moral distress for a nurse, such as a patient request for aggressive resuscitation deemed to be of greater harm than benefit for the patient. Mechanisms that balance the patient's preferences and values with the nurse's ethical commitments, and that allow for the transfer of care to another nurse who is competent to care for that patient, should be in place. Nurses recognize that ethics resources can be accessed to assist with uncertainty or disagreement about do-not-resuscitate decisions.

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Recommendations

The American Nurses Association recommends that:

- Nurses act to respect human dignity in supporting the patient's right to accept, refuse, or terminate treatment and be given necessary support throughout the decision-making and treatment process, including resuscitation decisions (ANA, 2015, p. 2).
- Nurses actively participate in ensuring the responsible and appropriate use of interventions regarding do-not-resuscitate orders through active involvement in evaluation, revision, and implementation of established institutional policies (ANA, 2015, p. 2).
- Nurses care for patients with do-not-resuscitate orders as they would care for any other patient, including respect and advocacy for the patients' preferences and values, promotion of well-being, and alleviation of suffering (ANA, 2015, p. 2).
- Nurses support the patient's wishes in reviewing and revising advance directive decisions and comply with the patient's wishes (The Joint Commission, 2018; CMS Medicare Requirements, 2018). Further, they promote advance care planning conversations and are knowledgeable about the benefits and limitations of various advance directive documents (ANA, 2015, p. 3).
- Nurses provide accurate, complete, and understandable information in a manner that facilitates an informed decision and are available to assist with weighing the benefits, burdens, and risks of available options in treatment, including the choice of no treatment (ANA, 2015, p. 2).
- Nurses advocate for using an interdisciplinary, collaborative approach when making decisions about resuscitation. Nurses foster discussions with the health care team, patient, and family (or designated surrogate), and ensure that the patient's wishes are respected.
- Nurses recognize that moral distress may be associated with do-not-resuscitate decision-making and should seek support as needed for themselves, health team members, patients, and families.
- Nurses seek opportunities to learn more about the evidence associated with do-not-resuscitate orders, as well as best practices for approaching patients and families when do-not-resuscitate orders may be part of the plan of care.

Summary

ANA supports the right of patients to self-determination. This right includes the right to be free from unwanted treatment, including resuscitative efforts. The Code of Ethics with Interpretive Statements (2015) Provisions 1.2, 1.3, 1.4, and 2.3 provide support for this position statement.

Nurses have an ethical obligation to support patients in their choices, and, when needed, to support surrogate decision-makers when they make decisions on a patient's behalf. ANA supports mechanisms that encourage nurses to more fully participate in goals-of-care discussions with patients and families, including discussions regarding do-not-resuscitate orders.

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