Preventing Safety Hazards Associated With Do-Not-Resuscitate Orders

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Do-not-resuscitate orders can promote patients’ dignity near the end of life, but they also can carry safety hazards associated with miscommunication and inappropriate withdrawal of certain kinds of care. Oncology nurses have a responsibility to identify these potential hazards and to intervene as necessary.

At a Glance
• Oncology nurses have an obligation to ensure that do-not-resuscitate (DNR) orders and do-not-intubate orders are followed correctly and that patients do not receive unwanted care near the end of life.
• Oncology nurses must verify that patients with advance medical directives have DNR orders that appropriately correspond to those directives.
• Patients’ safety must be protected by ensuring that DNR orders are not overinterpreted so that important kinds of care are not wrongly withheld from patients with DNR orders.

W hen a patient with cancer has a do-not-resuscitate (DNR) order in place, the nurse has several responsibilities to ensure the patient’s safety and dignity. First, the nurse must guarantee that the order is followed correctly and that the patient does not receive unwanted measures in the event of a cardiac or respiratory arrest. Second, the nurse must ensure that physicians and other clinicians do not overinterpret the DNR order and withhold interventions that are important to the patient’s safety and comfort. Finally, the nurse must do as much as possible to clarify any ambiguities in the patient’s plan of care and to ensure that the patient, family members, physicians, and nurses all have a common understanding of the patient’s preferences and needs.

History
The DNR order was first formalized during the mid-1970s, about 15 years after modern CPR was developed (Burns, Edwards, Johnson, Cassem, & Truog, 2003). With the informed consent of the patient or the patient’s legal surrogate, the physician entered an order that the patient should not receive CPR. These orders were typically placed after the patient (or surrogate) and the physician had mutually decided that the patient’s prognosis was too poor to justify invasive, and possibly futile, interventions in the event of cardiac arrest. DNR orders were intended only to prohibit CPR and did not imply anything about the patient’s broader plan of care (Beach & Morrison, 2002).

Do-Not-Resuscitate Orders Today
Historically and today, the simplest—and, yet, not so simple—task associated with DNR orders is to ensure that they are conveyed and followed correctly. When communication is poor among the medical and nursing staff regarding a patient’s DNR status, CPR is sometimes inappropriately initiated after an arrest (Goldstein, 2006; Saitta & Hodge, 2013; Sehgal & Wachter, 2007). This problem is particularly challenging outside of hospital settings. Many states allow physicians to write “universal DNR” or “out-of-hospital DNR” orders in accordance with patients’ advance directives. However, when cardiac arrests occur at home or in public, emergency medical responders may initiate CPR if they do not immediately see clear documentation of DNR orders (Veysman, 2010).

In inpatient settings, a basic intervention for avoiding DNR miscommunication is the use of color-coded wristbands (Marcus, 2015; Schiebel et al., 2013). These wristbands should be colored consistently across institutions and care settings. The Pennsylvania Patient Safety Authority received a near-miss report in 2005 in which resuscitation was almost withheld from a patient. A nurse had erroneously placed a yellow wristband (meaning DNR) on the patient, even though the patient did not have a DNR order. The nurse was familiar with a different hospital’s color scheme, in which a yellow band meant “restricted extremity” (Pennsylvania Patient Safety Authority, 2008).

A related basic nursing task is to ascertain whether the patient has a legal advance directive. Such legal directives...
can take several forms. Living wills give instructions for care in the event that the patient becomes too incapacitated to communicate about treatment preferences. Medical powers of attorney, also known as medical proxies, give a family caregiver or other agent the power to make medical decisions on the patient’s behalf if the patient becomes incapacitated. If the patient’s advance directive includes instructions not to perform CPR, the nurse should ensure that the providers have entered a corresponding DNR order for the patient. Nurses must read the patient’s advance directive carefully and ensure that every member of the healthcare team understands the directive’s details. In a case study by Katsetos and Mirarchi (2011), a DNR order was wrongly placed and treatments were wrongly withheld from an 89-year-old patient. Healthcare workers had glanced at the patient’s advance directive (which said that he did not want CPR or any other intervention) but did not read the directive carefully enough. The directive specified that the patient did not want interventions “if I should be in a terminal condition or a state of permanent unconsciousness,” which he was not (Katsetos & Mirarchi, 2011, p. 631).

Overinterpretation and Ambiguity

A second safety hazard surrounding DNR orders is the risk of overinterpretation—that is, the risk that physicians and other healthcare workers will wrongly withhold interventions that have nothing directly to do with resuscitation. One widely publicized event occurred in New Orleans, Louisiana, in the aftermath of Hurricane Katrina, when patients with DNR orders at Memorial Medical Center were placed last in line for flood evacuation regardless of their overall prognosis (Fink, 2013).

In a study that presented physicians with hypothetical scenarios, Beach and Morrison (2002) found that physicians were less likely to say that they would order dialysis, intubation, or transfer to the intensive care unit for patients with DNR orders, even though the DNR orders by themselves specify nothing about those interventions. Similarly, Fritz, Fuld, Haydock, and Palmer (2010) found that physicians and nurses believe that a wide variety of interventions—including nursing observation frequency, IV fluids, and phone calls from nurses to physicians—are, or should be, reduced after a DNR order is placed.

Other studies, by contrast, have provided reassuring evidence that DNR orders are not always overinterpreted. Azad, Siow, Tafreshi, Moran, and Franco (2014) found that 270 inpatients with DNR orders in an oncology unit in Australia continued to receive fluids, antibiotics, blood transfusions, and other interventions as indicated by their clinical condition. Similarly, Baker, Kane, Rai, Howard, and Hinds (2010) found that patients with pediatric cancer who had DNR orders in a U.S. setting continued to receive interventions (with the exception of chemotherapy) at nearly the same rate as their peers who did not have DNR orders. McAdam, Barton, Bull, and Rai (2005) found that nurses’ understanding of DNR orders improved from 1989–2003, with nurses in 2003 being much more likely to understand that active treatment can still be appropriate for patients with a DNR status.

Conclusion

The most important role for nurses is to assess the patient’s wishes for, and understanding of, the overall plan of care. Because the nurse spends a great deal of time at the bedside, the nurse may be the person most likely to notice discrepancies between the patient’s and the physician’s understanding of the plan of care. As Sanders, Schepp, and Baird (2011) said, “Nothing can be assumed about a patient’s plan of care from a DNR order alone” (p. 15). If the physician has failed to have a thorough conversation with the patient and his or her family members about goals of care and potential interventions, the nurse must encourage that conversation. In addition, the nurse should be sensitive to the fact that the patient’s preference for more aggressive versus less aggressive end-of-life care may change frequently over time (Fried, O’Leary, Van Ness, & Fraenkel, 2007).

When patients decide that they do want aggressive treatment to cease, their treatment plan is typically changed to “comfort measures only.” Unlike the placement of a DNR order, this is a major change in the plan of care. The oncology nurse should be skilled in delivering palliative measures at the end of life.

The nurse also should be familiar with the strengths and weaknesses of various emerging programs to reduce the ambiguity surrounding DNR orders. The most prominent emerging program is the Physician Orders for Life-Sustaining Treatment (POLST), a model that has been adopted by 18 states, while several other states are exploring similar models (National POLST Paradigm, 2015). Unlike most advance directives, POLST orders are tailored specifically to a patient’s current illness. And unlike advance directives, POLST documents result directly in the creation of medical orders. These orders allow patients to specify their preferences concerning a variety of potential interventions. The model varies across states, but it generally allows patients to specify their wishes concerning a variety of potential interventions, including CPR, intubation, artificial airways, and feeding tubes (Fromme, Zive, Schmidt, Olszewski, & Tolle, 2012). Those are the kinds of detailed preferences that are sometimes listed on advance directives, but the POLST model is physician-initiated and reaches a much larger population of patients.

References


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