American Academy of Nursing on Policy

Reconsideration of do not resuscitate orders in the surgical/procedural setting

Introduction

The American Academy of Nursing has long endorsed advance care planning and end-of-life conversations as essential components in the care of all persons but especially for those with critical, chronic, or complex conditions (American Academy of Nursing, 2010; The Palliative and End of Life Care Expert Panel, 2013; Tilden et al., 2012). The Institute of Medicine affirms the importance and necessity of having such conversations with patients in their recent report titled *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* (Institute of Medicine, 2014). This report asserts that conversations regarding end-of-life care should be ongoing and involve all pertinent members of the health care team, the patient, and the patient's family members/significant others (Institute of Medicine, 2014). Nurses have a crucial role in the health care team in ensuring that conversations regarding end of life have occurred (AACN, 2005). Resultant care decisions, including resuscitation preferences, should be respected by all members and in all settings of the health care delivery environment inclusive of the surgical/procedural setting.

Patients facing life-limiting illnesses and the need for end-of-life care deserve the highest level of quality and compassionate care. Attention should be given to planning for the prevention and treatment of pain, continuity of care, support for informed decision making, and focused efforts to meet their spiritual and existential needs.(Institute of Medicine, 2014; National Priorities Partnership, 2008). Many patients with critical, complex, and/or chronic conditions are now living longer and may desire surgical or procedural intervention to relieve distressing symptoms, improve function, or possibly enhance survival. These procedures are often conducted by health care providers unfamiliar with the patient's/family's history, values, goals, and preferences (Institute of Medicine, 2014). An estimated 15% of end-of-life patients with do not resuscitate (DNR) orders may be scheduled for surgery or interventional procedures (Association of periOperative Nurses, 2009; Byrne, Mulcahy, Torres, & Catlin, 2014; Hooper, 2010). However, the issues surrounding the management of DNR orders in surgical and procedural settings remain complex and in many facilities unresolved. This policy brief provides background and practice/policy recommendations.

Background

General anesthesia, by definition, implies the suppression of respiration and the performance of procedures such as endotracheal intubation. All forms of anesthesia, including the administration of procedural sedation, have the capacity to compromise respiratory and/or cardiovascular stability. During the surgical or procedural period, it may be impossible to distinguish between a cardiac or respiratory arrest related to anesthetic administration, procedural intervention, or the natural progression of the disease process (Byrne et al., 2014; Nurok, Green, Chisholm, Fins, & Liguori, 2014). Given the confounding impact of these interventions on the natural evolution of the patient's health status, it is understandable that the presence of a DNR order during this period can give rise to practice and ethical challenges.

Before the 1990s, DNR orders were automatically suspended during the perioperative/procedural period without input from the patient or family. Justification for this suspension was based on the frequently blurred boundaries between interventions associated with both anesthesia administration and resuscitation. However, the passage of the Patient Self-Determination Act in 1990 (Patient Self-Determination Act, 1990) stimulated a re-evaluation of the common practice of DNR suspension during the perioperative/procedural period (Ball, 2009; Nurok et al., 2014).

The American Society of Anesthesiologists (ASA) published an initial guideline addressing the management of the patient with a DNR order in the perioperative setting in 1993 (ASA, 2013; Ball, 2009; Byrne et al., 2014; Nurok et al., 2014) followed by a statement from the American College of Surgeons in 1994 (American College of Surgeons, 2014; Ball, 2009; Byrne et al., 2014; Nurok et al., 2014) and the Association of periOperative Nurses and the

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American Society of PeriAnesthesia Nurses in 1995 and 1996, respectively (American Society of PeriAnesthesia Nurses, 2011; Association of periOperative Nurses, 2009; Byrne et al., 2014). These statements consistently support the patient's right to self-determination, required reconsideration, and maintenance of the DNR order during the surgical/procedural period. Should a patient/family elect to suspend a DNR status for a surgery/procedure, the ASA (2013) specifically outlines three distinct alternatives to a full DNR order. These alternatives should only be considered upon extensive consultation and discussion between the patient/family and the surgical/procedural health care team. The ASA-recommended alternatives (ASA, 2013) include the following:

1. Full attempt at resuscitation: the patient/family elects for a suspension of the DNR during and immediately after the procedure, electing for full resuscitative efforts during this period.
2. Limited attempt at resuscitation defined with regard to specific procedures: the patient/family may elect limited resuscitation with regard to certain resuscitative procedures (i.e., chest compressions, mechanical ventilation, or chemical intervention), which should or should not be initiated.
3. Limited attempt at resuscitation defined with regard to the patient's goals and values: the patient/family allows the surgical/procedural team to use their clinical judgment to determine appropriate resuscitation efforts dependent on the situation and the patient's stated goals and values.

Despite the long-standing consensus regarding perioperative/procedural management of DNR status among professional specialty organizations in the field, health care providers often fail to adequately discuss DNR status and determine patient preferences for acceptable interventions before surgical/procedural intervention (Brindley, 2013; Burkle, Swetz, Armstrong, & Keegan, 2013; Cooper, Powers, & Cobb, 2012; Knipe & Hardman, 2013; Redman, Brasel, Alexander, & Schwarze, 2012; Schwarze, Redman, Alexander, & Brasel, 2013; Williams & Howe, 2013). Nurses must use skilled communication techniques to advocate for patients and pursue collaboration to ensure that these conversations occur (AACN, 2005).

Recommendations

The American Academy of Nursing recommends the following to improve hospital policies and practice related to reconsideration of DNR orders in the surgical/procedural setting.

Policy Recommendations (American College of Surgeons, 2014; ASA, 2013; American Society of PeriAnesthesia Nurses, 2011; Association of periOperative Nurses, 2009; Byrne et al., 2014; Institute of Medicine, 2014).

- All facilities providing surgical and/or interventional procedures should establish policies and protocols directing the management of the DNR patient undergoing a surgical/interventional procedure. These policies should contain/mandate the following:
  - A DNR status **will not** be automatically suspended before a surgery/procedure and/or the administration of an anesthetic or sedative agent.
  - Before a scheduled surgery/procedure and/or the administration of an anesthetic or sedative agent to a patient with an active DNR, the patient/family should be informed of the risks, benefits, implications, and possible outcomes associated with the planned procedure and associated anesthesia/sedation.
  - The patient/family should then be asked to clarify wishes regarding DNR management during the perioperative/perianesthesia period. Clarification before elective procedures should be attempted when appropriate.
    - This discussion will be initiated by the surgeon/proceduralist and reviewed/confirmed by the anesthesia/sedation provider.
  - The patient/family may choose to keep a full DNR order during the perioperative/perianesthesia period.
  - Per ASA (2013) guidelines, one of three acceptable DNR alternatives may be selected should the patient/family elect to temporarily suspend the DNR:
    - Full attempt at resuscitation
      - A full suspension of DNR is requested, consenting to the use of any resuscitation procedures that may be appropriate during the perioperative/perianesthesia period
    - Limited attempt at resuscitation defined with the regard to specific procedures
      - The patient/family may elect to refuse specific resuscitation procedures (i.e., chest compressions, defibrillation, or intubation).
    - Limited attempt at resuscitation defined with regard to the patient's goals and values
      - The patient/family may allow the anesthesia provider in collaboration with the surgeon/proceduralist to use clinical judgment in determining which resuscitation procedures are appropriate given the presenting situation and the wishes of the patient/family.
  - The selected alternative will be documented in the informed consent and medical record and communicated to the surgical team as a component of the preoperative and intraoperative time-outs as well as with all postoperative handoffs of care.

- If complete or partial suspension of the DNR is selected, documentation and team communication will include the following:
  - Duration of DNR suspension/limitation to include a specific reinstatement time
    - Duration may vary based on the extent of the surgery/procedure and associated system support required. Although an outpatient or simple surgery/procedure may dictate suspension/limitation through discharge from the facility or postanesthesia care unit, a more extensive surgery/procedure may dictate suspension/limitation for a longer period.
  - If limited resuscitation with regard to specific procedures is selected, a clear description of approved/refused interventions must be clearly documented and communicated.
  - If limited resuscitation based on patient goals/values is selected, a clear description of the stated goals and values of the patient should be documented and communicated.

Staff Education and Support (American Academy of Nursing, 2010; American College of Surgeons, 2014; American Society of PeriAnesthesia Nurses, 2011; ASA, 2013; Association of periOperative Nurses, 2009; Institute of Medicine, 2014).

- Education of students in the health care professions should include interprofessional training regarding the management of patients and families during palliative/end-of-life care.
- Ongoing clinical education for all health care professionals providing care in the perioperative/perianesthesia setting should include regular review of the perioperative/perianesthestic management of the DNR patient to include the opportunity for interprofessional role play and discussion.
- Institutions should provide for rapid resolution processes for moral/ethical conflicts that may arise to include the following:
  - Irreconcilable differences between the surgeon and anesthesia team regarding planned DNR management during the perioperative/perianesthesia period
  - Provision for reassignment of any health care provider with a moral objection to the patient/family decision

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