



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.

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Key words: communication; continuity of care; end-of-life care; hospice; palliative care; treatment plans

Digital Object Identifier: 10.1188/15.CJON.667-669

When 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