AORN

POSITION STATEMENT

Perioperative Care of Patients with Do-Not-Resuscitate or Allow-Natural-Death Orders

PREAMBLE

Nurses have a responsibility to uphold the rights of patients.[1,2,3] It has been reported that approximately 15% of patients who have do-not-resuscitate or allow-natural-death orders undergo surgical procedures and anesthesia management.[4] These procedures often are for palliative care, to relieve pain or distress, to facilitate care, or to improve the patient's quality of life. Do-not-resuscitate or allow-natural-death orders should not mean that all treatment is stopped and the need for medical and nursing care is eliminated, but rather that the patient has made certain choices about end-of-life decisions.[5,6] A patient's rights do not stop at the entrance to the operating or procedure room. Automatically suspending a do-not-resuscitate or allow-natural-death order during surgery undermines a patient's right to self-determination.[7] Professional organizations support developing policies to address do-not-resuscitate or allow-natural-death orders in the operating or procedure room.[7,8,9,10,11]

POSITION STATEMENT

Patient autonomy must be respected and is the professional responsibility of the health care team. The perioperative registered nurse, as a patient advocate, has an ethical and moral responsibility to the patient. Therefore, AORN believes that:

- reconsideration of do-not-resuscitate or allow-natural-death orders is required and is an integral component of the care of patients undergoing surgery or other invasive procedures;[7,9,12,13]
- 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 or allow-natural-death orders before initiating anesthesia, surgery, or other invasive procedures;[9,12,14]
- clear identification methods (eg, standardized wrist bands) for the patient who has do-not-resuscitate or allow-natural-death orders may decrease the risk for miscommunication;[15] and
- use of acronyms and abbreviations (eg, DNR, DNAR, AND) should be discouraged to decrease the risk of miscommunication.[6,16,17]

AORN believes the following strategies should be followed during reconsideration of do-not-resuscitate or allow-natural-death decisions:

Communication with the patient and patient's family members

- The patient's physicians and anesthesia care providers are responsible for discussing and documenting issues with the patient and/or family members to determine whether the do-not-resuscitate or allow-natural-death orders are maintained or completely or partially suspended during anesthesia and surgery.[9,12]
- The discussion should include:
    - goals of the surgical treatment,

  - potential for resuscitative measures and a description of what these measures include (eg, whether withholding resuscitation compromises the patient's basic objectives for surgery); and
  - potential outcomes with and without resuscitation.[7,9,12]

Communication with the health care team

- Preoperatively the health care team and the patient or surrogate should communicate about do-not-resuscitate or allow-natural-death decisions.
- In accordance with patient privacy and confidentiality, the health care organization should develop a standard method of communication that informs all direct care providers of the patient's decisions, which may include standardized wrist bands to indicate do-not-resuscitate or allow-natural-death status.
- Throughout the process, the patient has the right to modify any decision. Changes should be communicated to all direct care providers.[18]
- Patient situations that may require further ethical deliberation before surgical intervention may benefit from consultation with the hospital's ethics advisory committee.
- Appropriate information should be provided to the perioperative team in order to support the patient's or surrogate's health care decisions.[9,13]

Documentation

- The preoperative reconsideration discussion of do-not-resuscitate or allow-natural-death decisions should be clearly documented and reported in the hand-off communication to direct perioperative care providers.
- If the patient has chosen to suspend or modify the do-not-resuscitate or allow-natural-death orders during the intraoperative period, a specific time frame should be defined for reinstating the pre-existing do-not-resuscitate or allow-natural-death orders in accordance with the patient's or surrogate's decisions.

Staff assignments

- If the perioperative registered nurse has a moral objection to the patient's decision, he or she should be allowed to make a reasonable effort to find another perioperative registered nurse to provide care to the patient.
- If another perioperative registered nurse is not available, the patient's decision will be upheld, recognizing that there are times when a patient's decisions take precedence in a clinical situation.
- If the perioperative registered nurse identifies another team member's moral objections to the patient's decision, he or she should assist with facilitating reassignment of the individual.

GLOSSARY

Allow Natural Death: A specific directive, written by a physician, to promote discussions with the patient and his or her family members about end-of-life decisions (eg, intubation, mechanical ventilation, IV fluids, medications, types of nutrition, comfort measures) in proactive terminology (eg, guiding caregivers and families in the direction of what action to take as opposed to what action not to take), thus shifting the focus and providing clarity about the intent of the care that will be provided to the patient.

Do-not-resuscitate order: A specific directive, written by a physician, mandating that cardiopulmonary resuscitation should not be performed.

Do-not-resuscitate decision: The patient's or surrogate's directive regarding end-of-life choices.
Required reconsideration: An event that allows a patient or surrogate to participate in decisions about the use of procedures and interventions (eg, cardiopulmonary resuscitation, intubation, medication administration) that the patient or surrogate would permit during the perioperative phase and that offers caregivers an opportunity to explain the significance of cardiac arrest and resuscitation in the perioperative setting.

REFERENCES

1. AORN explications for perioperative nursing. In: *Perioperative Standards and Recommended Practices*. Denver, CO: AORN, Inc; 2008:633-660.

2. AORN standards of perioperative professional practice. In: *Perioperative Standards and Recommended Practices*. Denver, CO: AORN, Inc; 2008:23-26.

3. Medicare and Medicaid Programs; Advance Directives. 60(123) *Fed Regist*. (June 27, 1995) 33262-33294 (codified at 42 CFR §417, 430, 431, 434, 483, 484, and 489).

4. ECRI Institute. Do-not-resuscitate orders. *Healthcare Risk Control*. 2008;2(Ethics 3):1-13.

5. Reeder JM. Do-not-resuscitate orders in the operating room. *AORN J*. 1993;57(4):947-951.

6. Venneman SS, Narnor-Harris P, Perish M, Hamilton M. "Allow natural death" versus "do not resuscitate": three words that can change a life. *J Med Ethics*. 2008;34(1):2-6.

7. American Society of Anesthesiologists. Ethical guidelines for the anesthesia care of patients with do-not-resuscitate orders. October 17, 2001. http://www.asahq.org/publicationsAndServices/standards/09.pdf. Accessed October 31, 2008.

8. American College of Surgeons. Statement on advance directives by patients: "Do Not Resuscitate" in the operating room. *Bulletin of the American College of Surgeons*. 1994;79(9):29. http://www.facs.org/fellows_info/statements/st-19.html. Accessed October 31, 2008.

9. Fallat ME, Deshpande JK; American Academy of Pediatrics Section on Surgery, Section on Anesthesia and Pain Medicine, and Committee on Bioethics. Do-not-resuscitate orders for pediatric patients who require anesthesia and surgery. *Pediatrics*. 2004;114(6):1686-92.

10. Considerations for development of an anesthesia department policy on do-not-resuscitate orders. American Association of Nurse Anesthetists. http://www.aana.com/resources.aspx?ucNavMenu_TSMenuTargetID=51&ucNavMenu_TSMenuTargetType=4&ucNavMenu_TSMenuID=6&id=709. Accessed October 31, 2008.

11. American Nurses Association. Position statement on nursing care and do-not-resuscitate decisions. Revised 2003.

http://nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/EthicsandHumanRights.aspx(Membership required).Accessed October 31, 2008.

12. Bernat JL. Ethical issues in the perioperative management of neurologic patients. *Neurol Clin*. 2004;22(2):457-471.

13. Ewanchuk M, Brindley PG. Perioperative do-not-resuscitate orders--doing “nothing” when “something” can be done. *Crit Care*. 2006;10(4):219.

14. Morrison W, Berkowitz I. Do not attempt resuscitation orders in pediatrics. *Pediatr Clin North Am*. 2007;54(5):757-771.

15. Sehgal NL, Wachter RM. Identification of inpatient DNR status: A safety hazard begging for standardization. *J Hosp Med.* 2007;2(6):366-371.

16. Truog RD, Waisel DB, Burns JP. Do-not-resuscitate orders in the surgical setting. *Lancet.* 2005;365(9461):733-735.

17. Murphy P, Price D. How to avoid DNR miscommunications. *Nurs Manage*. 2007;38(3):17, 20.

18. Guarisco KK. Managing do-not-resuscitate orders in the perianesthesia period. *J Perianesth Nurs*. 2004;19(5):300-307.

RESOURCES

McGraw K. Should do-not-resuscitate orders be suspended during surgical procedures? *AORN J*. 1998;67(4):794-799.

Saver C. Knowing when to stop: DNR in the OR. *OR Manager*. 2007;23(11):17-18, 21.

Original approved by the House of Delegates, Atlanta, Georgia, March 1995
Reaffirmed by the Board of Directors: October 1999
Reaffirmed by the Board of Directors: December 2004
Revision; approved by House of Delegates, March 2009
Sunset review: March 2014