Does a do not resuscitate status in an inpatient geriatric setting cause a reduction in quality of palliative nursing care, preventing the facilitation of a good death?

Introduction

The do not resuscitate (DNR) status means that the patient or a surrogate authority has expressed that should they go into cardiac or respiratory arrest, they do not wish for resuscitation or measures of life support to be carried out, (Crisp and Taylor, 2009). This aspect of palliative care is extremely relevant to the current New Zealand demographic as the population aged 65 years and above has increased from 11% of New Zealand's total population in 1991 to 13% in 2009 and it is expected to increase to as much as 21% by 2031 (Statistics New Zealand, 2009).

Desired Outcomes of the DNR

For patients and family members the primary concern regarding palliative care is that the prolongation of death would cause unnecessary suffering and reduction in quality of life (Cardozo, 2005).

- CPR is successful in lengthening the time of life in only one third of cases, with one in nine of recipients recovering enough to be discharged (Weiss and Hite, 2000).
- Those who were successfully resuscitated often experienced aggressive treatment leading to irreversible neurological deficits and impaired functional status (Yuen et al, 2011).

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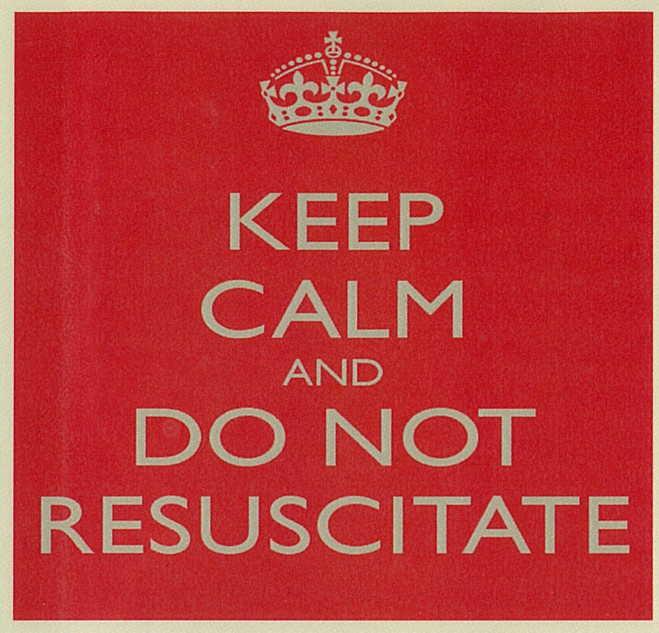

Limitations of the DNR

What limits the DNR is the lack of clarity that a stand-alone DNR expresses and the consequences of this.

- A DNR that is only implemented for unexpected arrests without limitations discussed and documented can often be misinterpreted or overruled by others. Nurses can find this isolated directive difficult to interpret when physicians are not immediately available (Tsang, 2010).
- Nursing care can be influenced following the implementation of the DNR decision. Activities that showed reduction were those around monitoring through basic nursing and invasive treatments, these changes in consideration of the dying patient's quality of life (Park, et al 2011).

Implications and Recommendations

The action of implementing a DNR order alone can still fail to meet identified outcomes. Therefore DNR order should never be implemented without also documenting the limits and method of care the patient wishes to receive., as the method of nursing care following implementation of DNR orders is greatly dependent on the boundaries of care the DNR order dictates.

In order to promote the idea of patient-centred end of life care, nurses should always initiate discussion after recognising a DNR order when the patient is still well. Additional undergraduate instruction for nurses and physicians surrounding goals of palliative care and DNR discussions would be a step towards encouraging this action.

References

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PICOT Category	Information Relating to Question	Explanation
Population	Adults over 65 years of age experiencing palliative care in an inpatient setting.	Over 65 years of age is defined as geriatrics (Crisp & Taylor, 2009) and the inpatient setting allows for evaluation of care and implementation of a DNR status.
Intervention	The implementation of a DNR order.	To examine the impact of having signed a DNR order on the method of care that is implemented when dying.
Comparison/Control	Adults over 65 years of age who are experiencing palliative care, who do not have DNR status.	Compared with those in the same demographic who are in the process of dying and cardiopulmonary resuscitation is available as a treatment option.
Outcome	A quality of care that facilitates the process of a good death	While death is the ultimate outcome of a DNR order, I want to examine whether that death is deemed positive or traumatic.
Time	The time period between establishing DNR status and death.	Unable to set a specific time frame, as the process of dying is individualised and varied.

Using PICOT, my question was then refined to "Does a do not resuscitate status in an inpatient geriatric setting cause a reduction in quality of palliative nursing care, preventing the facilitation of a good death?".