Advance Directives and Do Not Resuscitate Orders

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ABSTRACT

Unexpected situations can happen at any age. Anyone over the age of 18 can have an advance directive, and all adults are recommended to have an advance directive in place. Yet, the majority of the U.S., population and nursing home residents do not have an advance directive. Treatment in the final days of life is often hampered by lack of the patient’s decision-making capacity and legal documentation of wishes. An advance directive provides helpful written instructions for health teams and families when a patient is unable to make independent health care decisions. Various categories of advance directives exist, as well as barriers to achieve and carry out patient preferences during a medical misfortune, expected disease outcome or age.
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Statement of Learning Need

Clinicians need to understand legal processes and documentation requirements of patient wishes regarding treatment and life-sustaining measures in the event of an unforeseen event or expected outcome of illness and an end-of-life condition. Often, patients and family members hesitate and depend on health clinicians to support them through decision-making.

Course Purpose

To provide health clinicians with knowledge of advance directive and do-not-resuscitate orders to support patients during unanticipated health crises and end-of-life decision-making make known their desires and to ensure patient wishes related to their health care needs are carried out.
Target Audience

Advanced Practice Registered Nurses and Registered Nurses
(Interdisciplinary Health Team Members, including Vocational Nurses and Medical Assistants may obtain a Certificate of Completion)

Course Author & Planning Team Conflict of Interest Disclosures

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There is no commercial support for this course.

Please take time to complete a self-assessment of knowledge, on page 4, sample questions before reading the article.

Opportunity to complete a self-assessment of knowledge learned will be provided at the end of the course.
1. An individual may detail the medical treatments and life-sustaining measures the individual wants or does not want in the event of a serious or terminal illness in a document called a

   a. healthcare proxy.
   b. living will.
   c. durable power attorney for healthcare.
   d. do not resuscitate order.

2. POLST stands for the

   a. Pre-hospital Orders for Life Support Therapies.
   b. Philadelphia Organization of Life Support Treatments.
   c. Physician Orders for Life-Sustaining Treatment.

3. A medical power of attorney (POA) is the same as

   a. a durable power of attorney for healthcare.
   b. a healthcare proxy.
   c. a healthcare agent.
   d. All of the above

4. The type of advance directive that specifically specifies that an individual does not want CPR performed is a

   a. living will.
   b. healthcare proxy.
   c. power of attorney (POA).
   d. do not resuscitate order.

5. When choosing a healthcare proxy, this should be someone who

   a. will carry out the person’s wishes if that becomes necessary.
   b. can separate his or her own wishes from that of the individual.
   c. the individual knows and trusts.
   d. All of the above
Introduction

An advance directive describes a person’s preferences regarding end-of-life care. Because unexpected situations can happen at any age, all adults are advised to have an advance directive. Anyone over the age of 18 can have an advance directive, which has many proven benefits, such as a decreased rate of hospitalization at the end-of-life, an increased compliance with a patient’s end-of-life wishes, greater patient autonomy, and a greater likelihood of dying at home.

Scenarios And Common Types Of Advance Directives

Advance directives have slowly become more common and, although as recently as 2007 most people in the United States did not have an advance directive, current research shows that 70% of older Americans have an advance directive.\textsuperscript{1,2} A 2010 study of adults age 60 or older who died between 2000 and 2006 found that 42% required decision-making about treatment in the final days of life, but 70% lacked decision-making capacity. Of those lacking decision-making capacity, around one-third did not have advance directive planning.

An advance directive - and there are several forms of advance directive - describe a patient’s preferences regarding treatment when faced with a serious accident or a terminal illness. These legal documents speak for individuals when they are not able to speak for themselves, such as when someone is in a coma. Some examples of real life cases are raised below.

Case 1: Elderly Man with Cancer

A 76-year-old man with metastatic cancer is urgently admitted to the intensive care unit (ICU) with severe pneumonia and ends up dying
connected to a ventilator several days later. The man’s wife and son are very upset about what he was put through and state that he never would have wanted to die this way and ask why the physicians didn’t speak to him before it came to this.

**Case 2: Elderly Woman with Advanced Dementia**

An elderly woman with very advanced dementia is transferred to a hospital after falling out of bed and fracturing her hip. She lies in the hospital bed in a fetal position for four weeks, while the surgeons debate whether she is fit for an operation to fix the fracture. She screams in pain every time when moved for hygiene and skin protection. Eventually, the family begs the health team to transition to palliative care saying that this is not what she would have wanted.

**Case 3: Elderly Woman with a Stroke**

A former nurse in her early eighties, while living alone independently, tells her family that, if she has a stroke, she does not want to have a feeding tube and does not want to be kept alive to end up in a nursing home. She later does suffer a stroke and, when in the medical ward of the hospital, the medical clinicians, unaware of her wishes, are gaining consent for a feeding tube in preparation for placement in a nursing home. Her daughter does not know how to stand up to the clinicians and advocate for her mother. She feels very guilty and upset she is letting her mother down.

**Case 4: An Oncology Patient**

A 74-year-old man is admitted to the oncology ward on a Wednesday afternoon for chemotherapy the next day for recurrent cancer. He tells the health team that, if he has a cardiac arrest, he does not want to be
resuscitated. They agree to this and document it in the admission notes, but do not fill out a Do-Not-Resuscitate order and do not tell the rest of the health team. He suffers a cardiac arrest at two a.m., the next morning, and receives 30 minutes of chest compressions and other invasive procedures, before the resuscitation is abandoned. His family is very upset.

These real-life cases illustrate what can happen in the absence of an advance directive and meaningful discussion regarding end-of-life care. The goal is to prevent patients and families from suffering, and effective communication regarding an advance directive can help facilitate carrying forward patient wishes.

Advance directives are written instructions regarding medical care preferences. Physicians and family members will consult a person’s advance directive if they are unable to make their own health care decisions. Having written instructions can help reduce confusion or disagreement. Advance directives are typically discussed as if they are a single entity but the term refers to several documents involving end-of-life care, documents that include (but are not limited to) a living will, the medical power of attorney, physician orders for life sustaining treatment, and instructional directives. In most cases when the term advance directive is used, it refers to a living will and the designated medical power of attorney.

**Living Will**

A living will is a legal document that details the medical treatments and life-sustaining measures an individual wants or does not want, such as mechanical ventilation, tube feeding, or resuscitation, if they become seriously or terminally ill. Living wills can be made to be very specific, and they are the most widely used written advance directive.
In some U.S. regions, living wills may be called health care declarations or health care directives. A living will does not let a person select someone to make decisions for them. The National Hospice and Palliative Care Association website has links to state-specific guidelines for an advance directive, and these also contain a copy of a living will that can be filled out, printed, and saved: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289. These links also contain general information about advance directives and other forms such as appointment of a health care representative and designation of a conservator.

A living will should be signed, dated, and witnessed by two people. Preferably, individuals who are witnesses will know the person well but are not related to them and are not potential heirs or health clinicians. A number of states require a notary or permit a notary in lieu of two witnesses.

**Medical Power of Attorney**

The medical power or attorney (POA), which is also called the durable power of attorney for healthcare, healthcare proxy, or healthcare power of attorney, is a legal document that designates an individual — referred to as a health care agent or proxy — to make medical decisions for an individual, in the event the individual is unable to do so. However, it is different from a power of attorney authorizing someone to make financial transactions for the person. A POA is generally more useful than a living will; however, it may not be a good choice for those who do not have another person to trust to make these decisions for them.

A healthcare POA statute is part of the laws of all 50 states. They can guide loved ones and physicians when people are unable to make decisions about their own medical care. A living will cannot cover every possible situation.
Therefore, people might also want a medical POA in addition to a living will to designate someone to be their health care agent. This person will be guided by the living will but has the authority to interpret the person’s wishes in situations that are not described in the living will. A medical POA also might be a good idea if the individual’s family is opposed to some of his or her wishes or is divided about them.

**Physician Orders for Life-sustaining Treatment (POLST)**

The physician orders for life-sustaining treatment or POLST is similar to a living will. The POLST outlines detailed information about what care should or should not be administered in the event of an emergency or a terminal illness, but these are medical orders that have been signed by a physician. The Institute of Medicine and the National Quality Forum have both recognized the POLST as a valuable way to honor a patient’s preferences for end-of-life care and to improve end-of-life care.³ One of the primary values of a POLST is its portability and potential use by all health professionals in states where POLSTs are legally recognized.¹

The basic POLST form has three sections. Section A outlines the orders for cardiopulmonary resuscitation (CPR), for example, if the patient is unresponsive, not breathing, and does not have a pulse then attempt or do not attempt CPR. Section B outlines the medical interventions that should be used if the patient is breathing and has a pulse, such as use comfort measures only, give limited treatment, or provide full treatment. Section C details the orders for artificially administered nutrition, for example, no artificial nutrition via a feeding tube. The POLST and a living will with a designated POA are designed to supplement each other; for example, the living will involves the identification of a medical POA, which is completed by the patient and is a legal document, and the POLST is a medical order signed
by a physician. Detailed information on a POLST can be found on the National POLST website at www.polst.org.

**Instructional Directive**

The instructional directive has been proposed as a tool that can compensate for the limitations of an original living will. One such instrument, the medical directive, asks patients to decide in advance which of a dozen possible interventions they would favor in the event of any of four potential scenarios: 1) Coma with virtually no chance of recovery, 2) Coma with a small chance of recovery, probably to an impaired state, 3) Advanced dementia plus a terminal illness, and 4) Advanced dementia. The interventions include cardiopulmonary resuscitation, ventilator support, artificial nutrition and hydration, major surgery, dialysis, chemotherapy, minor surgery, invasive diagnostic tests, blood transfusions, antibiotics, simple diagnostic tests, and pain medications.

The problem with such a directive is that, despite its detail, it does not address the most common situations in the final years of life in which consideration might be given to limitation of treatment, such as moderate dementia or physical frailty. In addition, because there is no discussion of the goal of the interventions, the directive tool does not allow the individual to distinguish between short-term use of an intervention for a potentially reversible illness, and long-term treatment for a chronic condition. Finally, although patients in several studies have completed the medical directive, it is a formidable document, which may be quite intimidating in an older impaired population.

Health settings that support patients to make informed decisions at the end of life have decreased hospitalization rates and lower costs compared with
those that do not use directives to help patients make their own decisions. Instructional directives may significantly improve the ability of hospital-based physicians to ascertain patients’ preferences. A process that allows patients to identify an agent for health care decision-making should they become unable to for themselves exists in all U.S. jurisdictions. Surrogate decision-makers (discussed in the next section) can be appointed by the patient through an advance directive form or a durable power of attorney for health care.⁴

**Choosing A Health Care Agent**

Choosing a person to act as a health care agent is possibly the most important part of planning. This person should have the individual’s best interests at heart, understand their wishes and be able to act accordingly. He or she should also be mature and levelheaded, and comfortable with candid conversations. This person should not be chosen out of feelings of guilt or obligation. When choosing a healthcare proxy, ideally this is someone who 1) the individual knows and trusts, 2) can separate his or her own wishes from that of the individual, 3) will carry out the person’s wishes if that becomes necessary, 4) could be reached easily if he or she is needed, and 5) could cope with other family members or loved ones who want something different than the individual’s expressed wishes.

A health care agent does not necessarily have to be a family member. Some choose to have their health care decision-maker be different from the person they choose to handle their financial matters. It may be helpful, but it is not necessary, if the healthcare agent lives in the same city or state as the individual. The health care agent’s decision-making power is activated when the patient can no longer make healthcare decisions, and this power is
rescinded if the patient regains competency and the ability to make informed judgements about his/her health.4

Medical Treatments the Patient May Consider

In determining one’s wishes, the patient should think about their values, such as the importance of being independent and self-sufficient and what would make their life not worth living. Would the patient want treatment to extend life in any situation? Would they want treatment only if a cure is possible? Would they want palliative care to ease pain and discomfort if they were terminally ill? Although it is not possible to specify every possible procedure under every possible circumstance, it is possible to decide what kind of treatment one would want in most situations. There are certain common conditions (terminal, irreversible brain damage and dementing illnesses) and treatments commonly used in end-of-life situations that can be discussed in advance.

Since no one can predict what medical situations will arise, it is important to discuss the treatments that could be considered. It may help patients and their families to talk with a physician about these, especially if the individual has questions. It is also important to be aware that every medical intervention and treatment can be terminated at the patient’s request, even after they have been initiated. Advance directives can have as much or as little detail as one would like, and may include the following interventions and treatments. Decisions should be made about whether, when and for how long one would want to receive the following interventions and treatments.

Resuscitation

Resuscitation restarts the heart when it has stopped beating or in a case of cardiac arrest. Individuals should determine if and when they would want to
be resuscitated by cardiopulmonary resuscitation (CPR) or by a heart defibrillation device that delivers an electric shock to stimulate and restart the heart. Some people recover completely after having their heart restarted. Others have permanent brain damage from a lack of blood flow to the brain; this is most likely in people who have advanced, serious illness or when the heart has stopped for a long time. If CPR is not something a patient would want, they should talk to their physician to have a Do-Not-Resuscitate (DNR) order placed in their medical records.

**Mechanical Ventilation**

Mechanical ventilation takes over a person’s breathing if he/she is unable to do so. This requires an endotracheal tube be placed in the trachea down into the lungs. Patients who are intubated are not able to eat or speak and are sedated. Sometimes, mechanical ventilation is only needed for a short period of time. For instance, some people need mechanical ventilation just while they recover from a lung infection.

When deciding about mechanical ventilation, a person should consider whether the intervention will be used to get through a short-term problem that is expected to improve with treatment. If a ventilator is used, it is hard to know for sure if and when it will be able to be disconnected.

**Nutritional and Hydration Assistance**

When an individual is no longer able to eat, assistance can be provided through the administration of nutrients and fluids intravenously or via a tube inserted into the stomach. This can keep a person’s body going while he or she heals and gets strong. But it can also keep a person alive for a long time even if there is no chance the person will recover.
Dialysis

Dialysis is an invasive procedure that removes metabolic wastes from the blood and manages fluid levels if the kidneys no longer function.

Organ Donation

One can also specify in advance directives any wishes about donating body organs, eyes and tissues for transplantation or of their body for scientific study.

Comfort Care and Hospice

Comfort care is anything that can be done to soothe and relieve suffering while staying in line with the patients’ wishes. Comfort care includes managing shortness of breath, offering ice chips for dry mouth, limiting medical testing, providing spiritual and emotional counseling, and giving medication to treat pain, anxiety, nausea, or constipation. Often this is done through hospice, which may be offered in the home, in a hospice facility, in a skilled nursing facility, or in a hospital. With hospice, a team of health clinicians work together to provide the best possible quality of life in a patient’s final days, weeks, or months. After death, the hospice team continues to offer support to the family.

Hospice is a special concept of care designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to cure-oriented treatments. Hospice care neither prolongs life nor hastens death. Hospice staff and volunteers offer a specialized knowledge of medical care, including pain management.
The goal of hospice care is to improve the quality of a patient's last days by offering comfort and dignity. Hospice care is provided by a *team-oriented* group of specially trained professionals, volunteers, and family members. Hospice addresses all symptoms of a disease, with a special emphasis on controlling a patient's pain and discomfort. It also deals with the emotional, social, and spiritual impact of the disease on the patient and the patient's family and friends and offers a variety of bereavement and counseling services to families before and after a patient's death.

Research shows there are five factors patients consider important for a “good death.” An optimal discussion on advance directives would touch on all of the following:

1. Managing symptoms
2. Avoiding prolongation of dying
3. Achieving a sense of control
4. Relieving burdens placed on the family
5. Strengthening relationships

Additionally, research shows the five key parts to a successful discussion on advance directives are:

1. Do you know your illness?
2. Do you know your treatment options?
3. Who would you choose to make your decisions for you?
4. What would be an acceptable outcome if you suffered a serious illness?
5. What would you want done if your heart stopped or you stopped breathing?

These are questions clinicians should feel comfortable discussing with their patients on a consistent basis. This conversation can be prefaced with the
fact that it’s the intention of the clinician to act in the best interest of the patient, but for that to happen he or she must know of the patient’s wishes. As noted previously, it is optimal if the patients’ families are involved in these discussions as well.

**Do-Not-Resuscitate Orders**

A Do-Not-Resuscitate or DNR order is a request to *not* have cardiopulmonary resuscitation (CPR) if one’s heart stops or breathing stops. Cardiopulmonary resuscitation refers to the medical procedures used to restart a patient's heart and breathing when the patient suffers heart failure. It may involve efforts such as mouth-to-mouth resuscitation and external chest compression. Continued CPR may involve electric shock to the heart or cardiac defibrillation, insertion of an endotracheal tube (intubation) to open the patient's airway, injection of medication into the veins or heart and in extreme cases, opening a patient’s chest to provide direct heart massage.

Advance directives do not have to include a DNR order, and one is not required to have an advance directive to have a DNR order. Unless given other instructions, medical staff will try to help any patient whose heart has stopped or who has stopped breathing. A DNR order will inform physicians and other health staff that the individual does not want to be resuscitated. The DNR order is part of the medical record. Health institutions and physicians in all states accept DNR orders.

Cardiopulmonary resuscitation, when successful, restores heartbeat and breathing and allows patients to resume their previous lifestyle. The success of CPR depends on the patient’s overall medical condition and how long the heart has been stopped. Age alone does not determine whether CPR will be successful, although illnesses and frailties that go along with old age often
make CPR less successful. When patients are seriously ill or terminally ill, CPR may not work or may only partially work, leaving the patient brain-damaged or in a worse medical state than before the heart stopped. In these cases, some patients prefer to be cared for without aggressive efforts after resuscitation.

Any adult can request a DNR order. This order is only about CPR and does not relate to any other treatment. Those with DNR orders can still receive medications, treatments, and any other care as ordered by the physician, as well as all emergency first aid care as necessary. Any necessary transfer to a higher level of care should take place as needed. In the event of a crisis, emergency medical services (EMS) should be immediately summoned and the DNR order should be presented to them upon arrival.

Before deciding to request a DNR order, the patient and family should speak with a physician about the overall health of the patient and the benefits and burdens CPR would provide. A full and early discussion with a physician will assure that the individual’s wishes regarding CPR will be known and respected. If a patient does not want CPR and has requested a DNR order, the physician must follow these wishes or 1) transfer care to another physician who will follow these wishes, and 2) begins a process to settle the dispute if the patient is in a hospital or nursing home.

If the patient’s DNR request results in a dispute that is not resolved within 72 hours, the physician must enter the order or transfer the patient to the care of another physician. Before making a decision about CPR, individuals and their loved ones need to understand both the burdens and benefits of CPR. These can vary depending on the individual’s underlying condition. The physician should be prepared to 1) describe the procedures, 2) address the
probability for successful resuscitation based upon the person’s medical condition, and 3) define what is meant by “successful” resuscitation. Defining *successful resuscitation* involves an understanding of what it means to the patient; Will the patient be able to leave the hospital? In what condition? If it is unlikely that the person will be able to leave the hospital, what can the resuscitation attempt accomplish?

When a physician does not think resuscitation would be successful, the reasons of why should be explained to the patient and family. If a patient requests a DNR order while at home, that order will follow the patient to a nursing home or hospital provided the patient or family member can show the DNR order to the health team. If a DNR order was initiated in a hospital setting, this will not necessarily carry over to the patient’s home or to a nursing home. In this case, the patient or the healthcare proxy should have a conversation with the physician and communicate the desire for a DNR order to be in effect after the patient leaves the hospital. Those living at home or in a nursing home with a DNR order may choose to wear a medical alert bracelet with a DNR medallion.

When a DNR order is discussed the physician might ask if a *do-not-intubate* (DNI) order is also wanted. Intubation may be considered separately from resuscitation because a person can have trouble breathing or might not be getting enough oxygen before the heart stops beating or breathing stops. If the person is intubated, cardiac or respiratory arrest might be averted. During intubation, the endotracheal tube is inserted through the mouth or nose into the trachea (windpipe) to assist breathing. A ventilation machine or ventilator may be connected to that tube to force oxygen into the lungs.
Refusal of resuscitation is not necessarily the same as refusal of intubation. It is important that all of those concerned understand the decisions being made since some institutional DNR policies include intubation, while others treat it separately. If a person does not want life to be mechanically sustained it is important to be sure that intubation is addressed as part of the discussion of DNR.

**Advance Directives and Surrogate Decision-maker**

Sharing one’s wishes is an important factor in the process of making the advance directives known. Injury, illness, and death are not easy subjects to talk about, but by planning ahead one can ensure that they receive the type of medical care they want. This also relieves the family of the burden of trying to guess what someone would want done. Those making such decisions as advance directives and DNR orders should be encouraged to discuss their wishes with their loved ones.

An important function of a written advance directive is designating a surrogate decision-maker. Clinicians can guide patients in choosing an appropriate surrogate who is familiar with the patient, can deal competently with crises, and respects and follows the patient's best interest and choices versus their own intentions. In studies that considered how surrogates predict patient desires and choices relative to end-of-life issues, it was found that surrogate preferences often mirrored those of the patient. Clinicians can encourage patients to select a surrogate with similar values who will support their choices. Additionally, the clinician can support the patient when communicating their goals, values, and treatment preferences to this individual, and encourage patients to discuss their goals, values, and treatment preferences with their surrogate as unanticipated clinical situations are discussed, and in particular when they have not been
documented in an advance directive.¹⁰

Advance directives should be in writing, and each state has its own laws regarding advance directives. Although it is not required, one may want to consult an attorney about this process. State-specific forms are available from a variety of websites, such as the National Hospice and Palliative Care Organization (at https://www.nhpco.org/). Once the forms have been filled out, copies should be given to the patient’s physician, the health care agent, and family members. Another copy should be kept in a safe but accessible place. It is also advisable for the patient to keep a card in a wallet that says they have a living will and where it can be found. Advanced care planning is most effective when it is a part of a coordinated effort involving physicians, patients, paramedics, nursing homes, and emergency rooms.

A model initiative is The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in Oregon, which has been adopted or is under consideration in many other states. The POLST website has sample downloadable forms, educational materials, a description of the core elements of a POLST paradigm program, and information on how to build a coalition of health care professionals to start such a program at www.ohsu.edu/polst/. An example of a POLST form is included later on.

**Reviews and Changes to Advance Directives**

As a person’s health changes or their perspective on life changes, they might reconsider some of their advance directives. Advance directives should be reviewed from time-to-time to see if revisions of the instructions are needed. People can change their mind about their advance directives at any time, as long as they are considered of sound mind to do so. Being of sound mind
means that one is still able to think rationally and communicate their wishes in a clear manner.⁴

To revise advance directives, the same steps are used as were to create them. The individual should get new advance directive forms to fill out, discuss the changes with friends, family and physicians. Then they should distribute copies of the new advance directives and ask everyone to destroy the earlier version. If there is not time to redo the paperwork, one can always cancel their advance directive by telling their doctor and family. Remember, a living will or medical POA goes into effect only if the person is unable to make medical decisions, as determined by their physicians.

**Barriers To End-Of-Life Care**

Questions about medical care at the end-of-life are of great concern today, partly because of the growing ability of medical technology to prolong life and partly because of highly publicized legal cases involving comatose patients whose families wanted to withdraw treatment. Many people want to avoid extending personal and family suffering by artificial prolongation of life if they are in a vegetative state or when there is no hope of recovery. The best way for one to retain control in such a situation is to record the preferences for medical care in advance and share those decisions with physicians, loved ones, and clergy. As previously described, advance directives are intended to communicate a person’s wishes in the event they are no longer able to do so for themselves. This is not only important on a personal level because failing to have advance directives can have an emotional impact on family members, and has financial implications as well.

Prior research in 2007 showed that patients who received information concerning advance directives were more likely to complete them if they
received assistance from a health care professional. Additionally, a 2009 study had found that one in 20 endotracheal intubations are unwanted, but patients’ wishes are not known until days afterward. These unwanted intubations result in an average of two days in an intensive care unit with a cost of $10,000 - $15,000 per incident. If only 25 to 50 unwanted intubations were avoided each year, the cost savings to the healthcare system would be approximately $250,000 to $750,000.

More recent research reports validate these earlier findings, indicating that patients with “more knowledge about end-of-life decision options than controls, were twice as likely not to want resuscitation and had preferences for not having resuscitation and intubation statistically significantly more frequently documented and significantly more orders to withhold resuscitation (57 vs 19%). In an unplanned subgroup analysis, at one-year follow up intervention patients received resuscitation and intubation less frequently than controls – among patients readmitted to the same hospital, only 2 (4%) of the participants who stated they did not want intubation at baseline received intubation, compared to 7 (22%) of controls”. Some studies have reported no significant difference between control groups and those receiving no intervention such as tools provided to patients in order for them to make informed end of life decisions.

Unfortunately, many clinicians continue to find it awkward to initiate a conversation concerning end-of-life issues. Some of the barriers that prevent health clinicians from discussing advance directives include lack of time, lack of privacy for discussion, the feeling that their patients are not sick enough to warrant a discussion of that intensity, lack of comfort in discussing end-of-life decisions, and insufficient training in managing these situations. A lack of effective communication between the health clinician and the patient
has been implicated, resulting in advance directives that did not accurately reflect the patients’ wishes. It is generally accepted that communication between the health team, patient and patient’s family, plays a key role in the discussion and implementation of these end-of-life decision-making and advance directives.

Summary

Advance directives and Do-Not-Resuscitate orders are important documents that ensure physicians, nurses, and all other members of the health team are acting in congruence with the wishes of patients. The importance of advance directives has been discussed, including some different types of advance directives such as living wills, durable power of attorney for healthcare, DNR orders, and instructional directives. It is important for all members of the healthcare team to be aware of advance directive documents and to be aware of their implications so they can provide appropriate end-of-life care to patients.
Glossary

The following terms and definitions will aid in an understanding of advance directives and types of end-of-life care encountered.

**Advance directive** - A general term that describes kinds of legal documents including living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

**Artificial nutrition and hydration** – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine, or a vein.

**Brain death** – The irreversible loss of all brain function. Most states legally define death to include brain death.

**Capacity** - In relation to end-of-life decision-making, a patient has medical decision-making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient’s ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

**Cardiopulmonary resuscitation** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone’s heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to
mimic the heart’s function and cause blood to circulate. Defibrillation and drugs also are used frequently to stimulate the heart.

**Do Not Resuscitate (DNR) order** - A DNR order is a physician’s written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

**Emergency Medical Services (EMS)** - A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders, and other ambulance crew.

**Healthcare agent** - The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice** - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person’s needs and wishes. Support is provided to the persons loved ones as well.
**Intubation** - Refers to endotracheal or nasotracheal intubation, the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-sustaining treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

**Living will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a “directive to physicians” or “healthcare declaration”.

**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the trachea.

**Medical power of attorney** - The person appointed to make healthcare decisions for someone who is unable to do so. healthcare agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.
Physician orders for life sustaining treatment (POLST) – A physician’s orders that details CPR preferences the types of medical interventions that should/should not be used, and preferences for the use of artificially administered nutrition.

Power of attorney – The legally recognized power to that gal document allows one person to act in a legal matter on another’s behalf regarding financial or real estate transactions.

Respiratory arrest - The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision-making for patients without advance directives.

Ventilator – A ventilator is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.
Example: POLST Form

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
To follow these orders, an EMS provider must have an order from his/her medical command physician

<table>
<thead>
<tr>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders for Life-Sustaining Treatment (POLST)</td>
</tr>
</tbody>
</table>

Last Name
First/Middle Initial
Date of Birth

FIRST follow these orders, THEN contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person’s medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

A

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
☐ CPR/Attempt Resuscitation
☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B, C and D.

B

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
☐ COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.
☐ LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.
Transfers to hospital if indicated. Avoid intensive care if possible.

C

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ANTIBIOTICS:
☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
☐ Use antibiotics if life can be prolonged

D

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:
Always offer food and liquids by mouth if feasible.
☐ No hydration and artificial nutrition by tube.
☐ Trial period of artificial hydration and nutrition by tube.
☐ Long-term artificial hydration and nutrition by tube.

E

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

Discuss with
☐ Patient
☐ Parent of Minor
☐ Health Care Agent
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other:

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Patient Goals/Medical Condition:

<table>
<thead>
<tr>
<th>Physician or PACRN/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature (Optional)</td>
</tr>
</tbody>
</table>

Signature of Patient or Surrogate
Signature (Optional)
Name (Print)
Relationship (Write ‘Self’ if ‘Patient’)
Please take time to help NurseCe4Less.com course planners evaluate the nursing knowledge needs met by completing the self-assessment of Knowledge Questions after reading the article, and providing feedback in the online course evaluation.

Completing the study questions is optional and is NOT a course requirement.
1. An individual may detail the medical treatments and life-sustaining measures the individual wants or does not want in the event of a serious or terminal illness in a document called a
   a. healthcare proxy.
   b. living will.
   c. durable power attorney for healthcare.
   d. do not resuscitate order.

2. POLST stands for the
   a. Pre-hospital Orders for Life Support Therapies.
   b. Philadelphia Organization of Life Support Treatments.
   c. Physician Orders for Life-Sustaining Treatment.

3. A medical power of attorney (POA) is the same as
   a. a durable power of attorney for healthcare.
   b. a healthcare proxy.
   c. a healthcare agent.
   d. All of the above

4. The type of advance directive that specifically specifies that an individual does not want CPR performed is a
   a. living will.
   b. healthcare proxy.
   c. power of attorney (POA).
   d. do not resuscitate order.

5. When choosing a healthcare proxy, this should be someone who
   a. will carry out the person’s wishes if that becomes necessary.
   b. can separate his or her own wishes from that of the individual.
   c. the individual knows and trusts.
   d. All of the above

6. True or False: A patient must have an advance directive to have a DNR order.
   a. True
   b. False
7. If a DNR order was initiated in a hospital setting, the effectiveness of the DNR after discharge from the hospital

a. does not necessarily carry over to the patient’s home.
b. will automatically carry over to the patient’s home.
c. will continue if the patient wears a medical alert bracelet.
d. will continue after discharge if the patient goes to a nursing home.

8. Refusal of resuscitation is not necessarily the same as refusal of intubation because

a. it does not apply to CPR.
b. all institutional DNR forms include intubation.
c. some but not all institutional DNR forms include intubation.
d. a person who has trouble breathing will also suffer respiratory arrest.

9. Advance directives may be changed

a. at any time.
b. as long as the person is of sound mind.
c. so long as the change is communicated to others.
d. None of the above

10. Statutes that allow decision-making for patients without advance directives are called

a. surrogate decision-making laws.
b. power of attorney legislation.
c. healthcare declarations.
d. living will laws.

11. A health care agent in a medical advance directive

a. does not necessarily have to be a family member.
b. must be a family member.
c. cannot also be the one named in a financial power of attorney.
d. must live in the same city or state as the patient.
12. A patient has medical decision-making capacity if

a. the patient is able to recite the correct date.
b. the patient can understand other, unrelated concepts.
c. the patient can understand the medical problem and the risks and benefits of the available treatment options.
d. the patient has been declared competent by a court.

CORRECT ANSWERS:

1. An individual may detail the medical treatments and life-sustaining measures the individual wants or does not want in the event of a serious or terminal illness in a document called a

b. living will.

“A living will is a legal document that details the medical treatments and life-sustaining measures an individual wants or does not want, such as mechanical ventilation, tube feeding, or resuscitation, if they become seriously or terminally ill.”

2. POLST stands for the

c. Physician Orders for Life-Sustaining Treatment.

“A model initiative is The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in Oregon, which has been adopted or is under consideration in many other states.”

3. A medical power of attorney (POA) is the same as

a. a durable power of attorney for healthcare.
b. a healthcare proxy.
c. a healthcare power of attorney.
d. All of the above [correct answer]

“The medical POA (which is also called the durable power of attorney for healthcare, healthcare proxy, or healthcare power of attorney) is a legal document that designates an individual — referred to as a health care agent or proxy — to make medical decisions for an individual in the event that they are unable to do so.”
4. The type of advance directive that specifically specifies that an individual does not want CPR performed is a

d. do not resuscitate order.

“A do not resuscitate (DNR) order is a request to not have cardiopulmonary resuscitation (CPR) if one’s heart stops or if they stop breathing.”

5. When choosing a healthcare proxy, this should be someone who

a. will carry out the person’s wishes if that becomes necessary.
b. can separate his or her own wishes from that of the individual.
c. the individual knows and trusts.
d. All of the above [correct answer]

“When choosing a healthcare proxy, ideally this is someone who: The individual knows and trusts; Can separate his or her own wishes from that of the individual; Will carry out the person’s wishes if that becomes necessary; Could be reached easily if he or she is needed; Could cope with other family members or loved ones who want something different than the individual’s expressed wishes.”

6. True or False: A patient must have an advance directive to have a DNR order.

b. False

“Advance directives do not have to include a DNR order, and one does not have to have an advance directive to have a DNR order.”

7. If a DNR order was initiated in a hospital setting, the effectiveness of the DNR after discharge from the hospital

a. does not necessarily carry over to the patient’s home.

“If a DNR order was initiated in a hospital setting, this will not necessarily carry over to the patient’s home or to a nursing home. In this case, the patient or the healthcare proxy should have a conversation with the physician and communicate the desire for a DNR order to be in effect after the patient leaves the hospital.”
8. Refusal of resuscitation is not necessarily the same as refusal of intubation because

c. some but not all institutional DNR forms include intubation.

“Refusal of resuscitation is not necessarily the same as refusal of intubation. It is important that all concerned understand the decisions being made since some institutional DNR policies include intubation, while others treat it separately. If a person does not want life mechanically sustained it is important to be sure that intubation is addressed as part of the discussion of DNR.”

9. Advance directives may be changed

b. as long as the person is of sound mind.

“Advance directives should be reviewed from time-to-time to see if revisions of the instructions are needed. People can change their mind about their advance directives at any time, as long as they are considered of sound mind to do so.”

10. Statutes that allow decision-making for patients without advance directives are called

a. surrogate decision-making laws.

“Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision-making for patients without advance directives.”

11. A health care agent in a medical advance directive

a. does not necessarily have to be a family member.

“A health care agent does not necessarily have to be a family member.”
12. A patient has medical decision-making capacity if
c. the patient can understand the medical problem and the risks and benefits of the available treatment options.

“In relation to end-of-life decision-making, a patient has medical decision-making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options.”

References Section
The References below include published works and in-text citations of published works that are intended as helpful material for your further reading.

ative%20and%20end%20of%20life%20care%20in%20the%20United%20States.&selectedTitle=1~150.


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