Advance Directives and Do Not Resuscitate (DNR) Orders

DANA BARTLETT, RN, BSN, MSN, MA

Dana Bartlett is a professional nurse and author. His clinical experience includes 16 years of ICU and ER experience and over 20 years of as a poison control center information specialist. Dana has published numerous CE and journal articles, written NCLEX material, written textbook chapters, and done editing and reviewing for publishers such as Elsevire, Lippincott, and Thieme. He has written widely on the subject of toxicology and was recently named a contributing editor, toxicology section, for Critical Care Nurse journal. He is currently employed at the Connecticut Poison Control Center and is actively involved in lecturing and mentoring nurses, emergency medical residents and pharmacy students.

ABSTRACT

Unexpected situations can happen at any age. Anyone over the age of 18 can have an advanced directive. 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. Advance directives provide helpful written instructions for health teams and families when a patient is unable to make their own health care decisions. Various categories of advance directives are discussed, including barriers to achieve and carry out patient preferences in the event of a medical misfortune or expected outcome of disease or age.
Continuing Nursing Education Course Planners
William A. Cook, PhD, Director, Douglas Lawrence, MA, Webmaster, Susan DePasquale, MSN, FPMHNP-BC, Lead Nurse Planner

Policy Statement
This activity has been planned and implemented in accordance with the policies of NurseCe4Less.com and the continuing nursing education requirements of the American Nurses Credentialing Center's Commission on Accreditation for registered nurses. It is the policy of NurseCe4Less.com to ensure objectivity, transparency, and best practice in clinical education for all continuing nursing education (CNE) activities.

Continuing Education Credit Designation
This educational activity is credited for 2 hours. Nurses may only claim credit commensurate with the credit awarded for completion of this course activity.

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

Course Purpose
To provide nurses and healthcare associates with knowledge of an advanced directive and do-not resuscitate orders.
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
Dana Bartlett, RN, BSN, MSN, MA, William S. Cook, PhD,
Douglas Lawrence, MA, Susan DePasquale, MSN, FPMHNP-BC - all have no disclosures.

Acknowledgement of Commercial Support
There is no commercial support for this course.

Activity Review Information
Reviewed by Susan DePasquale, MSN, FPMHNP-BC.

Release Date: 1/1/2016  Termination Date: 6/26/2017

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. The document that specifies which treatments you do and do not want is a:
   a. Healthcare proxy
   b. Living will
   c. Durable power attorney for healthcare
   d. Do not resuscitate order

2. POLST stands for:
   a. The Pre-hospital Orders for Life Support Therapies
   b. The Philadelphia Organization of Life Support Treatments
   c. The Physician Orders for Life-Sustaining Treatment
   d. The Physician Organization for Limited System Threats

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 specifies that you do not want to have 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

Advance directives describe people’s preferences regarding end-of-life care. Because unexpected situations can happen at any age, all adults are advised to have advance directives. Anyone over the age of 18 can have an advanced directive. A nationwide study conducted in 2007 determined that when advance directives are in place, they “offer an opportunity to avoid a potentially distressing and costly experience for frail older persons” (Alfonso, 2009). Another 2007 study found, however, that 85%-95% of the US population does not have an advance directive and only 70% of nursing home residents have some form of advance directive in their medical records (Alfonso, 2009).

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 planning directives.

Living wills and other advance directives describe preferences regarding treatment if one is faced with a serious accident or illness. These legal documents speak for the individual when they are not able to speak for themself — for instance, if one is in a coma. Some examples of real life cases are listed below:

Case 1:
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:
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 the nurses move her for hygiene and skin protection. Eventually, the family begs the doctors to transition to palliative care saying that this is not what she would have wanted.

Case 3:
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 doctors, 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 physicians and advocate for her mother. She feels very guilty and upset she is letting her mother down.

Case 4:
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 doctors 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 nursing staff. 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 advance directives and meaningful discussions regarding end-of-life care. The goal is to prevent patients and families from suffering, and effective communication regarding advance directives can help facilitate this.

**Advance Directives**

Advance directives are written instructions regarding medical care preferences. Physicians and family members will consult a person’s advance directives if they are unable to make their own health care decisions. Having written instructions can help reduce confusion or disagreement. Advance directives include the following categories discussed below.

**Living Will**

The living will is a written, legal document that spells out the types of medical treatments and life-sustaining measures an individual wants and does not want, such as mechanical ventilation, tube feeding or resuscitation if they become seriously or terminally ill. Living wills are the most widely used written advance directive.

In some states, 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. Downloadable, state-specific documents can be found at http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289. A living will should be signed, dated, and witnessed by two people; preferably individuals who know the person well but are not related to them and are not potential
heirs or health care providers. A number of states require a notary or permit a notary in lieu of two witnesses.

**Medical or health care power of attorney (POA)**

The medical POA 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. 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 don't have another person to trust to make these decisions for them. This can also be called a durable power of attorney for health care or healthcare proxy.

Living wills and POAs are now legal in all 50 states. They can guide loved ones and doctors when people are unable to make decisions about their own medical care. A living will can't 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 aren't 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.

**Instructional Directive**

This has been proposed in an attempt to compensate for the limitations of the original living wills. 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:

- Coma with virtually no chance of recovery
- Coma with a small chance of recovery, probably to an impaired state
- Advanced dementia plus a terminal illness
- 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.

Nevertheless, a randomized trial of another instructional directive, “Let Me Decide”, was able to demonstrate that nursing homes that used the directive had decrease hospitalization rates and lower costs compared with nursing homes that did not use the directives (Gillick, 2012). Instructional directives may significantly improve the ability of hospital-based physicians to ascertain patients’ preferences.
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:

- 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 handle it if other family members or loved ones wanted something different that the individual’s expressed wishes

A health care agent doesn’t necessarily have to be a family member. Some chose 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’s not necessary, if the healthcare agent lives in the same city or state as the individual.

What treatments to consider?

In determining one’s wishes, they should think about their values, such as the importance of being independent and self-sufficient, and what they feel would make their life not worth living. Would they 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 isn’t 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.

As stated above, no one can predict what medical situations will arise, it is important to discuss the following treatments. It may help to talk with a doctor 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, the following are some interventions and treatments that may be included.

*Resuscitation*

Resuscitation restarts the heart when it has stopped beating (cardiac death). One should determine if and when they would want to be resuscitated by cardiopulmonary resuscitation (CPR) or by a device that delivers an electric shock to stimulate the heart (defibrillation.) 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. If this is not something one would want, they should talk to their physician to have a DNR order placed in their medical records.

*Mechanical ventilation*

Mechanical ventilation takes over one’s breathing if they are unable to do so. This requires a tube placed in the trachea down into the lungs. Patients who are intubated are not able to eat or speak and are often on medications for
sedation. 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 this intervention, one should consider whether they’ll be using it to get through a short-term problem that is expected to improve with treatment. If a ventilator is used, however, it is hard to know for sure if and when it will be able to be disconnected. Consideration should be given to if, when and for how long one would want to be placed on a mechanical ventilator.

*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 in 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. Decisions should be made about whether, when and for how long one would want to be fed in this manner.

*Dialysis*

Dialysis removes waste from the blood and manages fluid levels if the kidneys no longer function. Determination should be made as to whether, when and for how long one would want to receive this treatment.

*Organ donation*

One can also specify in his or her advance directives any wishes he or she has about donating organs, eyes and tissues for transplantation or their body for scientific study.
Comfort care

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 for 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 healthcare providers works 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 chose 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 in order for that to happen, he or she must know what the patient’s wishes are. As noted previously, it is optimal of the patients’ families are involved in these discussions as well.
**Do Not Resuscitate (DNR) Orders**

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. Cardiopulmonary resuscitation - refers to the medical procedures used to restart a patient's heart and breathing when the patient suffers heart failure. CPR may involve efforts such as mouth-to-mouth resuscitation and external chest compression. Continued CPR may involve electric shock (defibrillation), insertion of a tube to open the patient's airway (intubation), injection of medication into the veins or heart and in extreme cases, open chest heart massage.

Advance directives do not have to include a DNR order, and one doesn’t have 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 tell the doctors and other medical staff that the individual does not want to be resuscitated. The DNR order is part of the medical record. Physicians and hospitals 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. Age alone does not determine whether CPR will be successful, although illnesses and frailties that go along with 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 at resuscitation upon their death.
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 necessary. In the event of a crisis, emergency medical services (EMS) should be immediately summoned and the Do Not Resuscitate order should be presented to them upon arrival.

Before deciding to request a DNR order, one should speak with a doctor about their overall health 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:

- transfer care to another doctor who will follow these wishes
- begin a process to settle the dispute if the patient is in a hospital or nursing home

If the dispute 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 individual’s underlying condition. The physician should be prepared to:

- Describe the procedures;
- Address the probability for successful resuscitation based upon the person’s medical condition;
• Define what is meant by “successful” resuscitation: Does “Successful” mean the person will 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?

If the physician does not think resuscitation would be successful, he or she should be willing to discuss the reasons why.

If a patient initiates a DNR order 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 medical and nursing staff. If a DNR order was initiated in the hospital setting, this will not necessarily carry over to the patient’s home or to a nursing home. In this case, the patient or healthcare proxy should have a conversation with the physician and communicate the desire for a DNR order for 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 doctor 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 actually stops beating or breathing stops (a cardiac or respiratory arrest). If this condition continues a full arrest will occur. If the person is intubated, cardiac or respiratory arrest might be averted. During intubation a tube is inserted through the mouth or nose into the trachea (windpipe) in order to assist breathing; a machine (ventilator) may be connected to that tube to push oxygen into the lungs.
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.

**Make the Advance Directives Known**

Sharing one’s wishes is an important factor in this process. Injury, illness and death aren't 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. They should let them know they are creating advance directives and explain their feelings about medical care and what they would want done in specific instances.

One study showed that even though patients believed both their family (87%) and doctors (90%) could accurately represent their wishes, neither family members nor doctors were able to adequately predict patient wishes on scenario testing with agreement ranging from 59% to 88% (Family Doctor, *Advance Directives and Do Not Resuscitate Orders*, 2012).

Advance directives should be in writing. Each state has its own laws regarding advance directives. Although it isn't 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. ¹

Once the forms have been filled out, copies should be given to one’s doctor, the person they have chosen as their health care agent and family members. Another copy should be kept in a safe but accessible place. It is also advisable to keep a card in one’s wallet that says they have a living will and where it can be found.

Advance 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 at the end of this course (pg. 26 – 27).

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.¹
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 doctors. Then they should distribute copies of the new advance directives and ask everyone to destroy the earlier version. If there isn't 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.

**Implications And Barriers**

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 their preferences for medical care in advance and share those decisions with physicians, loved ones and clergyman.

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 as failing to have advance directives can have an emotional cost for family members, but has financial implications as well. One 2009 study 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 (Alfonso, 2009).

Research from a Mayo Clinic study in 2007 showed that patients who receive information concerning advance directives were more likely to complete them if they received assistance from a health care professional (Silvester & Detering, 2011). Unfortunately, however, many clinicians continue to find it awkward to initiate a conversation concerning end-of-life issues. Some of the barriers cited by health care providers for not discussing advance directives include lack of time, lack of privacy for discussion, and feeling that their patients are not sick enough to warrant a discussion of that intensity. A 2008 study found that a lack of effective communication between the provider and the patient resulted in advance directives that did not accurately reflect the patients’ wishes, indicating that communication plays a key role in the discussion and implementation of these documents (Silvester & Detering, 2011).

**Summary**

Advanced directives and Do Not Resuscitate orders are important documents that ensure physicians, nurses, and other members of the healthcare team are acting in congruence with the wishes of those they are caring for. This course has described the importance of advance directives and defined some different types of advanced directives including living wills, durable power of attorney for healthcare, do not resuscitate orders and instructional directives. It is important for all members of the healthcare team to be aware of these documents and be aware of their implications so they can provide appropriate care to their patients.
Glossary

The following terms and definitions will aid your understanding of this course.

**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. Electric shock 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 involve 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 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 windpipe (or trachea).

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a 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.
Power of attorney – A legal document allowing one person to act in a legal matter on another’s behalf regarding to 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 of a 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

Pennsylvania Orders for Life-Sustaining Treatment (POLST)

First Name Initial
Last Name
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.

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.

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.

- FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Transfer to hospital if indicated. Avoid intensive care if possible.

- FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Additional Orders ________

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.

Additional Orders ________

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

Additional Orders ________

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

- 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.

Physician/PAC/NRP Printed Name: ________
Physician/PAC/NRP Phone Number: ________
Physician/PAC/NRP Signature (Required): ________

Signature of Patient or Surrogate: ________
Signature (Required): ________
Relationship: ________
Witnessed: ________
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. **The document that specifies which treatments you do and do not want is a:**
   a. Healthcare proxy
   b. Living will
   c. Durable power attorney for healthcare
   d. Do not resuscitate order

2. **POLST stands for:**
   a. The Pre-hospital Orders for Life Support Therapies
   b. The Philadelphia Organization of Life Support Treatments
   c. The Physician Orders for Life-Sustaining Treatment
   d. The Physician Organization for Limited System Threats

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 specifies that you do not want to have 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/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 the hospital setting,**
   *a. the patient should have a conversation with the physician and communicate the desire for a DNR order for after discharge.
   b. it will automatically carry over to the patient’s home.
   c. it will only be effective after discharge if the patient is wearing a medical alert bracelet.
   d. it will only be effective 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. p. 10
    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:**


**References Section**
The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although may appear within the study text.


The information provided in this course is general in nature, and is not designed to address any specific situation. This publication in no way absolves facilities of their responsibility for the appropriate orientation of healthcare professionals. Hospitals or other organizations using this publication as a part of their own orientation processes should review the contents of this publication to ensure accuracy and compliance before using this publication.

Hospitals and facilities that use this publication agree to defend and indemnify, and shall hold NurseCe4Less.com, including its parent(s), subsidiaries, affiliates, officers/directors, and employees from liability resulting from the use of this publication.

The contents of this publication may not be reproduced without written permission from NurseCe4Less.com.