



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

Resuscitative Decisions in the Emergency Care Setting

Description

In the emergency care setting, resuscitative decisions remain controversial issues that are encountered frequently. Ethical issues regarding cardiopulmonary resuscitation, life-sustaining treatment, medically unnecessary treatment, self-determination, advance directives, and new procedures are ongoing.¹ Legal issues arise with respect to state-to-state variances in care (i.e., National POLST Paradigm, advance directives, out-of-hospital do not attempt resuscitation (DNAR), living wills, power of attorney, minors, and expressed wishes).² Family dynamics regarding communication, decision making, and family presence can be challenging. Clinical barriers such as a lack of an advanced directive (or recent changes in status) and conflicts of interest arise. The issue of resuscitative decisions is magnified by population growth and the influx of chronically ill, older adults.¹ According to the U.S. Census Bureau (2014), between 2012 and 2060, the U.S. population is projected to grow from 314 million to 420 million, a 34% increase.³

Resuscitative decisions are often encountered after clinical deterioration or during end-of-life care.⁴ Such timing can make these decisions challenging for patients, their families, and the healthcare team. Various resuscitation decisions involve an advance directive focused on advocating, maintaining, withholding, or withdrawing resuscitation interventions. U.S. federal laws require healthcare facilities to comply with the Federal Patient Self Determination Act regarding advance directives, particularly when patients come into the emergency department with an established advanced directive.⁵

Furthermore, people of all nations, not just the United States, have fundamental rights which are represented by international human rights laws. Such international laws constitute a widely recognized network of rules and obligations that protect human rights such as self-determination.⁶ Critics say that international law is fragmented, is subject to the interpretive process, and can be challenged domestically. Arguably, the U.S. legislation is presumed to be consistent with international law.

Emergency nurses are in a key position to inform, educate, and advocate for patients and their families regarding advance care planning.² It is important that emergency nurses participate in the shared decision-making (SDM) process, which allows patients, surrogates, and clinicians to make collaborative healthcare decisions while considering the patient's values and preferences.^{7,8}



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Emergency nurses have immediate Emergency nurses respect the patient's autonomy, dignity, and right to self-determination in resuscitative decisions.
2. Emergency nurses collaborate with other healthcare professionals regarding resuscitation decisions and interventions.
3. Emergency nurses advocate for advance care planning, educate patients and their families on planning options, and verify documentation of code status in the healthcare record.
4. Emergency nurses support a patient and family-centered care (PFCC) approach to healthcare decisions.
5. Emergency nurses support family presence during resuscitation if the family desires to be present.
6. Emergency nurses participate in the development, implementation, and evaluation of resuscitative decision policies and protocols.

Background

The Patient's Bill of Rights, created by the American Hospital Association (AHA) in 1970 and revised in 1992, details the rights a patient can expect, including informed consent, quality care, privacy, and the right to an advance directive for healthcare.⁹ In 2010, the Patient's Bill of Rights was updated to provide further protection to insured patients by extending coverage to pre-existing conditions, protecting the patient's right to choose their own doctors, and end lifetime limits.¹⁰ This is based upon the principle that healthcare is a basic human right.

The Federal Patient Self Determination Act (PSDA) was enacted in 1990 and mandates that individuals can stipulate their choice to accept or opt out of medical treatment in an advance directive or by appointing someone as their legal surrogate.¹¹ PSDA is a federal law requiring hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations to comply with the following requirements: inform patients about their medical care options, periodically inquire



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

about the existence of a signed and dated advance directive, not discriminate against a person with an advance directive, ensure an advance directive is legally valid, and promote educational programs regarding advance directives.^{6,11,12} International human rights laws protect the principle of self-determination under Article I of the Charter of United Nations.⁶

An advance directive and the Do Not Resuscitate (DNR) order were initiated because of the adoption of the PSDA. An advance directive is a binding document that indicates an individual's decisions about their medical treatment.¹³ Two types of advance directive are the living will and medical power of attorney.¹⁴ A living will addresses treatments and procedures to perform when a person is terminally ill,¹⁴ whereas a medical power of attorney is a legal document that appoints a designated person (surrogate)^{8,15} to make medical decisions when a person is incapacitated, whether temporarily or permanently.

There are four levels of treatment to be considered during resuscitative care events: no resuscitation be attempted; only provide specified treatments as selected; comfort measures be provided; and all necessary and appropriate interventions be offered. The most widely recognized terminology and abbreviations include Do Not Attempt Resuscitation (DNAR),¹¹ or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR),¹⁴ Do Not Intubate (DNI),¹³ Comfort Measures Only (CMO), and Full Code (FC). More recently, some have suggested the addition of an alternative to DNR, or shock-only resuscitation (SOR). With this new status, patients would not receive chest compressions but could potentially receive defibrillation for what are considered shockable and reversible cardiac rhythms.¹⁶

DNAR is a term used to direct clinicians to withhold resuscitative measures¹⁶ in the event a patient goes into cardiopulmonary arrest; without a written DNAR order in the medical record, resuscitation efforts will be initiated if it is medically appropriate. Once the existence of a written DNAR is established, resuscitative efforts will be stopped. As part of a DNAR, a patient may choose to have a DNI, a term used to prevent intubation or mechanical ventilation.¹³ CMO is a term used to permit the natural dying process while affording maximum comfort which includes addressing the psychological and spiritual needs of both patient and family.¹⁷ Full Code is a term used to allow healthcare providers to attempt all resuscitative interventions including, but not limited to, cardiopulmonary resuscitation (CPR), advanced cardiac life support (ACLS), intubation, mechanical ventilation, and heroic measures.¹⁸ Although each state has its own version of an advance directive, there is dialogue about a national advance directive which would be transferable among states.¹⁹

When structured, advanced care planning is initiated early in the patient admission process or immediately following clinical deterioration, early planning may lead to greater patient involvement, self-determination and decision-making.⁴ PFCC is an approach to healthcare that recognizes the role of the family in providing medical care, encourages collaboration between the patient, family, surrogate, and health care professionals and honors individual and family strengths, cultures, and traditions.²⁰ In 2009, the ENA developed a clinical practice guideline for family presence as an option during



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

resuscitation which meets the family's psychosocial needs in a time of crisis and recommends a designated healthcare individual stay with the family to facilitate care.²¹

Resources

American College of Emergency Physicians (ACEP). (n.d.). Family presence fact sheet. Retrieved from: <http://newsroom.acep.org/index.php?s=20301&item=29931>

American College of Emergency Physicians (ACEP). (n.d.). How can an emergency department assist patients and caregivers at the end of life? Retrieved from: <http://www.emergencycareforyou.org/Be-Prepared/How-Can-An-Emergency-Department-Assist-Patients-And-Caregivers-At-The-End-Of-Life-/>

Emergency Nurses Association. (2012). Clinical Practice Guideline: Family Presence During Invasive Procedures and Resuscitation. Retrieved from https://www.ena.org/docs/default-source/resource-library/practiceresources/cpg/familypresencecpg3eaabb7cf0414584ac2291feba3be481.pdf?sfvrsn=9c167fc6_12

Congress.gov. (1990). H.R. 4449-Patient Self Determination Act of 1990. Washington, D.C. 101st Congress Hour of Representatives. Retrieved from Congress.gov website <https://www.congress.gov/bill/101st-congress/house-bill/4449>

National Institute on Aging. (2017). Understanding healthcare decision at the end of life. Retrieved from: <https://www.nia.nih.gov/health/understanding-healthcare-decisions-end-life>

References

1. Karnik, S., & Kanekar, A. (2016). Ethical Issues Surrounding End-of-Life Care: A Narrative Review. *Healthcare*, 4(2), 24. <http://doi.org/10.3390/healthcare4020024>
2. Breault, J. L. (2011). DNR, DNAR, or AND? Is language important? *The Ochsner Journal*, 11(4), 302–306.
3. Colby, S. L., Ortman J. M. (2014). The baby boom cohort in the United States: 2012 to 2060. Population estimates and projections. U. S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, 1-16. Retrieved from <https://www.census.gov/prod/2014pubs/p25-1141.pdf>
4. Perkins, G. D., Griffiths, F., Slowther, A-M, George, R., Fritz, Z., Satherley, P., ...Hawkes, C. (2016). Do-not-attempt-cardiopulmonary-resuscitation decisions: an evidence synthesis. *Health Services and Delivery Research, NIHR Journals Library*; 2016 Apr. (Health Services and Delivery Research, No. 4.11.) Available from: <https://www.ncbi.nlm.nih.gov/books/NBK355498/> doi:



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

- 10.3310/hsdr04110
5. Kelley, K. (1995). The Patient Self-Determination Act. A matter of life and death. *Physician Assist.*, 19(3), 53-56.
 6. Unrepresented Nations & Peoples Organization. (2017). Self-determination. Retrieved from: <http://www.unpo.org/article/4957>
 7. Turpin, S., & Vince, S. (2018). Transitions of Care and Disposition in Geriatric Emergency Medicine: Switzerland, Springer International Publishing; 329-43. Retrieved from <https://www.springer.com/us/book/9783319193175>
 8. Depuydt, P. (2018). Avoidance of Endotracheal Intubation in Esquinas, et al.'s Mechanical Ventilation in Critically Ill Cancer Patients. Springer International Publishing. p. 289-98.
 9. Fritz Z, Slowther A-M, Perkins GD. Resuscitation policy should focus on the patient, not the decision. *BMJ* 2017;356:j813.
 10. Kon, A. A., Davidson, J. E., Morrison, W., Danis, M., & White, D. B. (2016). Shared Decision Making in Intensive Care Units: An American College of Critical Care Medicine and American Thoracic Society Policy Statement. *Critical Care Medicine*, 44(1), 188–201. <http://doi.org/10.1097/CCM.0000000000001396>.
 11. Teno, J. M., Sabatino, C., Parisier, L., Rouse, F., & Lynn, J. (1993). The impact of the Patient Self-Determination Act's requirement that states describe law concerning patients' rights. *The Journal of Law, Medicine & Ethics*, 21(1), 102-8.
 12. Congress.gov. (1990). H.R. 4449-Patient Self Determination Act of 1990. Washington, D.C. 101st Congress Hour of Representatives. Retrieved from Congress.gov website <https://www.congress.gov/bill/101st-congress/housebill/4449>
 13. National Institute on Aging. (2018). Advance care planning: Healthcare directives. Retrieved from <https://www.nia.nih.gov/health/advance-care-planning-healthcare-directives>
 14. Hunsaker, A. E., & Mann, A. (2013). An analysis of the patient self-determination act of 1990. *Journal of Human Behavior in the Social Environment*, 23(7), 841-848. DOI: 10.1080/10911359.2013.809287
 15. Shah, R. D., Rasinski, K. A., & Alexander, G. C. (2013). The influence of surrogate decision makers on clinical decision making for critically ill adults. *Journal of Intensive Care Medicine*, 30(5), 278-85. DOI: 10.1177/0885066613516597
 16. Mandawat, A., Mandawat, A., Curfman, G., & Newby, L. K. (2018). A “shocking” new code status. *American Heart Journal*, 198, 1-3. DOI: <https://doi.org/10.1016/j.ahj.2017.12.004>.
 17. Blinderman, C. D. & Billings, A. (2015). Comfort care for patients dying in the hospital. *New England Journal of Medicine*, 373(26), 2549-2561. DOI: 10.1056/NEJMra1411746
 18. Veysnan, B. (2005). Full code. *Health Affairs*, 24(5), 1311-1316. DOI: 10.1377/hlthaff.24.5.1311
 19. Sabatino, C. (2016). Can my advance directives travel across state lines? *Bifocal*, 38(1). Retrieved from <https://www.americanbar.org/content/dam/aba/publications/bifocal/bifocalseptemberoctober2016.authcheckdam.pdf>



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

20. The Joint Commission. (2010). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission.
21. Emergency Nurses Association. (2012). Clinical Practice Guideline: Family Presence During Invasive Procedures and Resuscitation. Retrieved from https://www.ena.org/docs/default-source/resourcelibrary/practiceresources/cpg/familypresencecpg3eaabb7cf0414584ac2291feba3be481.pdf?sfvrsn=9c167fc6_12

Authors

Authored by

Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN

Reviewed by

2018 ENA Position Statement Committee Members

G. J. Breuer, RN, CEN, CCRN, FAEN
Judith Carol Gentry, MHA, BSN, RN, CEN, CPEN, CFRN, CTRN, CNML, NE-BC, RN-BC
Catherine J. Hesse, MSN, NP
Daniel E. Kane, MEd, BSN, RN, EMT-P, CEN, CFRN, CCRN, NREMT-P
Sue L. Leaver, MSN, RN, CEN
Cheryl Riwitis, MSN, RN, FNP, EMT-B, CEN, CFRN, FNP-BC, TCRN, FAEN
Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN
Sally K. Snow, BSN, RN, CPEN, FAEN
Elizabeth Stone, MSN, RN, CPEN
Chelsea T. Williams, MSN, RN, CEN, CCRN
Justin Winger, PhD, MA, BSN, RN, Chairperson

2018 ENA Board of Directors Liaison

Ellen Encapera, RN, CEN

2018 ENA Staff Liaison

Monica Escalante Kolbuk, MSN, RN, CEN

Developed: 1990



Position Statement

930 E. Woodfield Road, Schaumburg, IL 60173 | 800.900.9659 | ena.org

Approved by the ENA Board of Directors: September 1990.
Revised and Approved by the ENA Board of Directors: September 1992.
Revised and Approved by the ENA Board of Directors: September 1994.
Revised and Approved by the ENA Board of Directors: May 1996.
Revised and Approved by the ENA Board of Directors: July 1998.
Revised and Approved by the ENA Board of Directors: December 2000.
Revised and Approved by the ENA Board of Directors: July 2003.
Revised and Approved by the ENA Board of Directors: September 2010.
Revised and Approved by the ENA Board of Directors: July 2014.
Revised and Approved by the ENA Board of Directors: July 2018.

© Emergency Nurses Association, 2018.

This position statement, including the information and recommendations set forth herein, reflects ENA's current position with respect to the subject matter discussed herein based on current knowledge at the time of publication. This position statement is only current as of its publication date and is subject to change without notice as new information and advances emerge. The positions, information and recommendations discussed herein are not codified into law or regulations. In addition, variations in practice, which take into account the needs of the individual patient and the resources and limitations unique to the institution, may warrant approaches, treatments and/or procedures that differ from the recommendations outlined in this position statement. Therefore, this position statement should not be construed as dictating an exclusive course of management, treatment or care, nor does adherence to this position statement guarantee a particular outcome. ENA's position statements are never intended to replace a practitioner's best nursing judgment based on the clinical circumstances of a particular patient or patient population. Position statements are published by ENA for educational and informational purposes only, and ENA does not "approve" or "endorse" any specific sources of information referenced herein. ENA assumes no liability for any injury and/or damage to persons or property arising out of or related to the use of or reliance on any position statement.