Position Statement

Resuscitative Decisions: Maintaining, Withholding, and Withdrawing Resuscitative Interventions in the Emergency Setting

Description
It is a common occurrence in emergency settings for patients and their families to be faced with making resuscitative care decisions. Making those decisions and understanding the various resuscitative treatments such as maintaining, withholding, or withdrawing resuscitative interventions is often difficult for the patient and their family, as well as for the interprofessional team caring for the patient. The multiplicity of choices and the complexity of the decision-making process can result in misunderstanding and problems when implementing orders into practice. 

Do Not Resuscitate (DNR) is a procedural term long used by clinicians to indicate cardiopulmonary resuscitation (CPR) is not to be used as an intervention. It has been described as a process to limit aggressive interventions aimed at saving lives. Some complain that DNR is not a plan of care. Others worry that the implementation of a DNR order may preclude the use of treatment for a short-term problem and might not allow for the patient to be informed of the risks associated with the current plan of care or to make a separate choice under certain circumstances.

In contrast to DNR orders, use of the Allow Natural Death (AND) directive focuses on the patient’s care needs and less on procedural or clinical interventions. The AND order is thought to be a positive expression, more acceptable to patients and families, and the emphasis is on patient comfort and pain management.

Regardless, the principle importance of an advance directive is the initiation of a conversation regarding end-of-life (EOL) care. Patients with advance directives enter into hospice services earlier and receive those services longer than patients without advance directives. They also make decisions regarding where they will receive their EOL care.

Emergency nurses are in a position to educate and inform patients and their families regarding EOL decisions, as well as advocate that patient’s choices be supported and carried out by the healthcare team.

ENA Position
It is the position of the Emergency Nurses Association that:

1. Emergency nurses respect, affirm, and support the patient's autonomy and the family’s role in resuscitative decisions.
2. Emergency nurses encourage discussion regarding resuscitative decisions among the patient, their family, and the interprofessional team.
3. Emergency nurses, in collaboration with all members of the healthcare team, support and carry out a plan of care in accordance with the patient’s wishes.
4. Emergency nurses verify that Do Not Resuscitate (DNR), Allow Natural Death (AND), and/or Orders for Life Sustaining Treatment (OLST) are clearly documented, reviewed, and updated following facility policies.
5. Emergency nurses promote and participate in the development, implementation, and evaluation of resuscitative decision-making protocols and policies.
Background

The Patient Self-Determination Act (PSDA) of 1990 mandates the patient’s “right to participate in and direct healthcare decisions affecting the patient.”7 Any hospital receiving federal reimbursement is required to ask patients about the existence of an advance directive and inform them of their rights.8 Three types of options evolved following implementation of this mandate:

- The Do Not Resuscitate (DNR), which allows the patient to refuse treatment in spite of the fact that refusing treatment may lead to his/her death.
- Durable power of attorney for healthcare, which allows the patient to appoint someone else to exercise their right of autonomy if he/she were incapacitated.
- A living will, more popularly known now as an advance directive, which states the patient’s preference regarding resuscitative and treatment decisions.8

More than 20 states have instituted a type of directive such as the Physician Order for Life Sustaining Treatment (POLST) to ensure that patients’ and families’ wishes regarding resuscitative decisions be communicated across the healthcare continuum.9,10,11 These orders are meant to direct healthcare providers in any setting for maintaining, withholding, or withdrawing treatment. They are not meant as a replacement for the advance directive.11

Advance directives have the potential to be too limiting or too general in nature.3 They involve legal, ethical, and practical considerations, so it is essential for emergency nurses to advocate for best practice by being cognizant of and operationalizing advance directive policies in their facilities/communities.7 Nurses at all levels of care are urged to encourage discussions among patients, their families, and their interprofessional healthcare team regarding resuscitative decision-making, and support patients’ or their proxy’s decisions.2

Resources

ENA Clinical Practice Guideline: Family Presence During Invasive Procedures and Resuscitation
http://www.ena.org/practice-research/research/CPG/Pages/Default.aspx

ENA Position Statement: Palliative and End-of-Life Care in the Emergency Setting
http://www.ena.org/SiteCollectionDocuments/Position%20Statements/PalliativeEndOfLifeCare.pdf

References

Position Statement

915 Lee Street, Des Plaines, IL 60016-6569 • 800.900.9659 • www.ena.org


Authors

Authored and Reviewed by the Position Statement Committee
Diane Gurney, MS, RN, CEN, FAEN, Chair
Todd Baxter, MA, BA, RN, CEN
Gordon Gillespie, PhD, RN, CEN, CPEN, FAEN
Kathleen Patrizzi, MSN, RN, CEN, ACNS-BC
Robin Walsh, MS, BSN, RN

ENA 2014 Board of Directors Liaison
Sally Snow, BSN, RN, CPEN, FAEN

ENA Staff Liaisons
Susan Rajkovich, MBA, Director of Marketing
Andrea Alvarez, Marketing Coordinator

Developed: 1990.
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.


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, is only current as of the 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. Variations in practice and a practitioner’s best nursing judgment may warrant an approach that differs from the recommendations herein. ENA does not approve or endorse any specific sources of information referenced. ENA assumes no liability for any injury and/or damage to persons or property arising from the use of the information in this position statement.