Dnr order assignment

Often times at Medicine ward, I encouter patients family deciding to have a DNR or Do Not Resuscitate order. Once they decide, they have to sign the patients chart for legality purposes. But what is exactly DNR? A Do Not Resuscitate, or DNR order is a written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest.

Such an order may be instituted on the basis of an advance directive from a person, or from someone entitled to make decisions on their behalf, such as a health care proxy; in some jurisdictions, such orders can also be instituted on the basis of a physician’s own initiative, usually when resuscitation would not alter the ultimate outcome of a disease, and is designed to prevent unnecessary suffering.

Any person who does not wish to undergo lifesaving treatment in the event of cardiac or respiratory arrest can get a DNR order, although DNR is more commonly done when a person who has an inevitably fatal illness wishes to have a more natural death without painful or invasive medical procedures. In real life encounter at the ward, a patient was brought to the hospital because of CVA or cerebrovascular accident, the patient had continuous decrease in sensorium and decreased in vital signs despite nursing and medical interventions.

So, the patient is a candidate for intubation or we have to place a tube to the mouth to help the patients breath because some clotted blood might affect the respiratory center of the brain. But the family decided to avoid resuscitating the patient. Supposedly, we should intubate the patient and if the patient will go on cardiac arrest, we have to perform CPR and inject

epinephrine. Here are our nursing roles in DNR: Providing meticulous care of the patient, including making sure the patient is kept clean and dry.

Nurses can offer food, drinks, and a place to rest to the family and encourage them to take care of themselves during the dying process. Contacting local hospice centers and nursing organizations for more information. Performing a literature search to obtain current guidelines and to validate and initiate evidence-based practice. Forming multidisciplinary committees to assess and plan for appropriate end-of-life care and education. These committees should include upper management, physicians, pastoral care, nurses, and anyone else interested in this process.

Make sure to include people with differing opinions on the subject of end-of-life care so that all sides are incorporated into the final product. Seeking support from physician champions, such as oncologists, who routinely address end-of-life issues. Involving critical care nurses, physicians, intensivists, pulmonologists, and surgeons in discussions about end-of-life care and invite them to join committees. Allowing flexible work patterns and assignments for staff members who may become emotionally drained and need to change assignments.

Having supportive services in place to help nurses maintain emotional reserves and to give them an opportunity to vent their frustrations. Identifying crisis intervention teams that may be available if needed for nurses and families. Integrating pastoral care and psychological services to any committees that are formed. Writing and implementing policies, procedures, or protocols for withdrawing life-sustaining treatment according

to current national guidelines. Do not resuscitate does not mean no care; it means a different kind of care that can best be achieved through end-of-life protocols and education.