

Model Policy and Procedure for DNR Orders in Dialysis Facility

I. Policy

It is the policy of *[the name of the dialysis unit]* to respect the informed oral or written refusal of cardiopulmonary resuscitation (CPR) in the dialysis unit by patients with decision-making capacity or the health care agents for patients who lack decision-making capacity. In response to an informed refusal of CPR, *[the name of the dialysis unit]* will issue and honor a do-not-resuscitate (DNR) order for such patients.

II. Rationale for the Policy

CPR is not a successful therapy for most dialysis patients who undergo it. Patients who undergo and survive CPR may have major complications. Because dialysis patients already often bear considerable burdens as a result of dialysis and the frequent occurrence of co-morbid conditions, such as diabetes, congestive heart failure and peripheral vascular disease, many dialysis patients elect to limit the extent of life-prolonging medical care. Such limitations may include a decision to refuse CPR in the dialysis unit and request a DNR order. Honoring the decision of a patient with decision-making capacity (or the decision of a health care agent for a patient who lacks decision-making capacity) not to undergo CPR is ethically justified by the principle of respect for patient autonomy and legally justified by the doctrine of informed consent and the patient's right to self-determination. Furthermore, the performance of CPR on dialysis patients with significant co-morbid conditions who have an extremely poor prognosis with CPR violates the ethical principle of non-maleficance.

III. Definitions

Advance Directive A statement by a patient with decision-making capacity expressing his/her preference for a health care proxy and/or for future medical care in the event he/she becomes unable to participate in medical decision-making. All 50 states have one or more laws or regulations recognizing written advance directives and the rights of patients to have their wishes respected. There are two types of written advance directives: a living will (an instruction directive in which the patient gives directions for future medical care in the event of particular medical conditions, such as terminal illness or a persistent vegetative state); and a health care proxy (a proxy directive in which the patient designates a person to make decisions for him/her when the patient loses decision-making capacity). In some states the health care proxy is referred to as a medical power of attorney or durable power of attorney for health care. In some states both instruction and proxy directives may be combined into one advance directive form. Some patients may want to state their preferences verbally to their family and to dialysis staff and not put them into writing. Any expressed preferences should be documented in the patient's medical record. Such verbal statements constitute oral advance directives. (Since written advance directives are preferable from a legal perspective, the remainder of this policy and procedure refers to written advance directives.)

Attending Physician A licensed physician with staff privileges in the dialysis facility selected by or assigned to the patient who has primary responsibility for treatment of the patient. (In the case of dialysis patients, this physician is likely to be the nephrologist primarily assigned to the supervision of the patient's dialysis and related care.) If more than one physician shares the responsibility for care of the patient, any of those physicians may act as the attending physician under this policy.

Cardiopulmonary Resuscitation (CPR) A procedure performed to attempt to support and restore ventilation and circulation in a patient experiencing cardiac arrest (systole, ventricular fibrillation, or pulseless electrical activity) or respiratory arrest (cessation of respiratory effort). It includes establishment and maintenance of an airway, assisted ventilation, chest compressions, establishment of intravenous access, cardiac monitoring, administration of medications, defibrillation or other control of arrhythmias, and immediate care after resuscitation.

Decision-Making Capacity The capacity of a patient to 1) understand his/her medical condition; 2) appreciate the consequences (benefits and burdens) of various treatment options including non-treatment; 3) judge the relationship between the treatment options and his/her personal values, preferences and goals; 4) reason and deliberate about his/her options; and 5) communicate his/her decision in a meaningful manner. Assessment of decision-making capacity is a clinical judgment made by the patient's attending physician.

Do Not Resuscitate (DNR) Order An order written in an appropriate document (medical record, specially formulated advanced care directive, standardized form according to applicable state law or regulation, etc.) that indicates the patient's (or health care agent's) decision to refuse CPR in the event of cardiac or respiratory arrest in the dialysis unit. This order does not restrict the provision of standard measures in dialysis treatment such as fluid resuscitation for intradialytic hypotension, nor does it preclude other forms of care meant to provide comfort and to relieve suffering. A DNR order only becomes effective when the patient has experienced a cardiac or respiratory arrest.

Health Care Agent, Proxy, Surrogate, Guardian, Medical Power of Attorney, or Durable Power of Attorney for Health Care A person who, in accordance with applicable state laws, has been selected by a patient, or who, in accordance with applicable state laws, has been appointed, and has been given the authority to make informed health care decisions for the patient in the event the patient loses decision-making capacity. The appropriate terminology may vary from state to state, but the intent to allow an individual to pre-assign decision-making authority to another person is common among all such instruments. To the extent permitted by applicable state law, the health care agent may have the opportunity to be guided in his/her decision-making by prior knowledge of the patient's wishes through conversations and/or the stipulations in a written advance directive.

Living Will The living will, also known as an instruction directive, indicates a patient's wishes to be followed if he/she loses decision-making capacity. Wishes may refer to care

in the event of particular medical conditions such as a terminal illness or a persistent vegetative state. The patient may indicate that he/she wishes under certain circumstances to have or continue treatments such as dialysis or CPR or to discontinue or refrain from such treatments.

Patients Without Decision-Making Capacity A patient who in accordance with the clinical judgment of the attending physician, clinical practice guidelines, and applicable state laws, has been declared to lack the capacity to: 1) understand his/her medical condition; 2) appreciate the consequences (benefits and burdens) of various treatment options including non-treatment; 3) judge the relationship between the treatment options and his/her personal values, preferences and goals; 4) reason and deliberate about his/her own options; and 5) communicate his/her decision in a meaningful manner.

IV. Statement of Principles

1. Patients with decision-making capacity have the same legal and ethical right to request DNR orders in dialysis facilities as they do in hospitals, nursing homes, and other medical or custodial facilities. Patients can better ensure that their legal and ethical rights are secured if they subsequently lose capacity to make medical decisions by executing an advance directive in which they designate a health care agent and state their preferences, including a preference for a DNR order in the dialysis unit if that is their wish. (See Appendix A)
2. For patients with decision-making capacity who have not appointed a health care agent, dialysis units should learn from them whom they wish to choose for a health care agent so that this person can participate in medical decisions for the patient in the event the patient loses decision-making capacity. When a patient has not designated a health care agent and temporarily or permanently lacks decision-making capacity to designate a health care agent, the dialysis facility must determine who has the legal authority to make medical decisions for the patient and take such actions as are necessary to secure the designation of the health care agent according to applicable state laws.
3. There is no legal or ethical difference between a patient requesting a DNR order in a dialysis facility or deciding to forgo dialysis therapy, each of these actions being legitimate manifestations of patient self-determination and the right to refuse therapy. On a clinical basis, a DNR order may be an entirely appropriate decision by a patient who recognizes that his/her quality of life may be quite adversely affected by even a "successful resuscitation" in the face of varying degrees of co-existing morbidity. Requesting a DNR in a dialysis facility may mean that the patient considers his or her quality of life to be adequate to continue dialysis treatment until cardiac or respiratory arrest occurs, even if this occurs while on dialysis, and possibly as a complication of the dialysis treatment itself.
4. Education of dialysis patients and their legal agents about the outcomes of CPR for patients with end-stage renal disease and other co-morbid conditions is essential for patients to make informed decisions about CPR.

5. Dialysis units are obligated to identify and respect the informed preferences of patients regarding performance of CPR. Education about CPR and inquiry about patients' preferences may be conveniently conducted during required semi-annual long-term care planning meetings, though the process of advance care planning should begin as soon as medically indicated. Patients who request a DNR order in the dialysis facility should be encouraged to make advance preparations for their death to relieve the burden on their health care agent and family (see Appendix B).
6. To accommodate patients who refuse CPR in the dialysis unit and subsequently die there, dialysis units are obligated to have a procedure for treating such patients at and after the time of cardiorespiratory arrest with comfort, dignity, and respect (See V. Procedure below).
7. A patient or the patient's health care agent has the right to revoke a DNR order at any time.
8. If the patient requests an in-facility DNR order, the dialysis facility is obligated to continue to provide the patient with the normal range of dialysis treatment and supportive services provided to all other patients.
9. Inherent in quality end-of-life care is the provision of bereavement support to the patient's family. Dialysis units should arrange for such support to be made available to the family either through the dialysis unit or through services available in the community.

V. Procedure

1. The dialysis unit personnel (physicians, nurses, social workers, dietitians, and patient care technicians) are to identify patients who want a DNR order in the dialysis unit through the long-term care planning process and/or in conversations that are appropriate as medical complications arise. Patients who request a DNR order in the dialysis unit are to be encouraged to complete an advance directive for a DNR order in the dialysis unit (see Appendix A), especially if they have not been issued DNR identification (card or bracelet) applicable under state law.
2. Attending physicians are to issue DNR orders for patients with decision-making capacity who want them or at the request of health care agents for patients who lack decision-making capacity. The DNR order is to be recorded in the patient's medical record, a DNR label is to be attached to the inside front cover of the chart, and the notation "DNR" is to appear in the special directions section of individual dialysis treatment sheets.
3. When a patient with a DNR order has a cardiorespiratory arrest in the dialysis unit, dialysis personnel are to screen the patient from other patients and move the patient to a private area of the facility as soon as possible and proper.

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4. The dialysis nurse in charge is to notify the attending physician and follow the physician protocol to pronounce the death of the patient.
5. The dialysis nurse in charge and/or the social worker should reassure other patients and staff that everything possible is being done to respect the affected patient's wishes and to promote his/her comfort and dignity.
6. The attending nephrologist, the nurse in charge, or the social worker is to notify the health care agent of the patient's death and to inquire about funeral home preferences, if not previously determined (see Appendix B).
7. Dialysis unit personnel are to notify the funeral home of the patient's death and request immediate pick-up of the body.
8. If required by state law, dialysis unit personnel are to notify the Medical Examiner (Coroner) and to inform him/her that the attending physician has been notified and the patient has been pronounced dead using the physician protocol for pronouncement of death. (The Medical Examiner telephone number is to be readily available in the dialysis unit.)
9. The nurse in charge is to document the death and procedures followed in the patient's progress notes and prepare an incident report, if appropriate, according to dialysis unit policy and procedure.