Would standardized best practice guidelines to help patients, families and caregivers making end-of-life decisions for care be beneficial?

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Understanding the basis of personal clinical practice and identifying a potential research question

Initiating resuscitation for an incapacitated, palliative, or neurologically deceased person can be ethically and emotionally distressing for the nurses and health care team, and family involved in these situations. When a family or caregiver refuses to initiate a do-not-resuscitate (DNR) or life support withdrawal due to lack of knowledge, understanding and support, it is upsetting to all parties involved. Maintaining life support or not implementing a DNR plan of care is not always in the best interest of the patient.

Throughout my career in a regional emergency and trauma centre, and currently in the cardiac setting at the University of Ottawa Heart Institute, these situations are a daily part of my nursing experience. I have had several opportunities to meet with the families who are making these end-of-life decisions. Each circumstance, while different, revolves around making the best decision for the well-being and dignity of the person who is incapacitated. In this area of practice, there are no set guidelines besides the Canadian Nurses Association's Code of Ethics for Registered Nurses to assist the nurse in assisting people to make these end-of-life care decisions. If there was a standardized teaching initiative for nurses faced with these aspects of care and patients and families faced with these decisions, everyone involved would be ensured that the outcome would be the best decision made under the circumstances.

Overall, there is a general lack of knowledge of procedure, protocols and laws that revolve around withholding or withdrawing life support and end-of-life care. There is still the belief among laypeople that withdrawing life support or consenting to a DNR order will result in the withdrawal of expert and ethical treatment of their loved ones. If a best practice standard of care guideline was developed, then nurses would have guidance on how to best prepare and assist those making end-of-life decisions.

Identify the clinical problem and formulate the question

The question is: should there be a formal best practice guideline and education initiative for nurses to follow in order to educate and help patients, families and caregivers when they are faced with end-of-life decisions, and would such an initiative be beneficial?

Conduct a literature search and critically appraise the literature findings

After searching the Laurentian University Library journal database using "teaching for end-of-life care" nothing came up. Using the search title "decisions about DNR" showed various articles that did not show that there were any standards for educating nurses or patients. There are several articles in relation to palliative care. However, these end-of-life decisions are not always made under the guidance of a palliative care support setting. Nurses are responsible for "promoting informed decisions under the code of ethics (Canadian Nurses Association 2008).

A study done by Westphal and McKee (2009) to "identify how nurses and physicians perceive end-of-life care showed that nurse-physician understanding and communication can be improved". The survey showed that nurses were more likely than physicians to address these issue. The survey also indicated that "the reluctance of approaching the subject, (of end-of-life care), stems from lack of knowledge on the part of the health care team and fears of legal implications" (Westphal & McKee, 2009). Another article by Ward (2009) states that the three topics of advanced directive initiation, withholding and/or withdrawing life-support, and DNR need to be discussed (Ward 2009).

Describe the potential impact of this issue in clinical practice and the care that is delivered

If best practice guidelines were initiated for discussing end-of-life care, it would promote an increased understanding and informed decision-making for patients, families and care-givers facing end-of-life decisions for care. It would also set a standard of practice for all of the health care team. A standardized education package that could be used in these situations would be beneficial and also answer many questions for patients and families, thereby allowing nurses to focus on end-of-life care.

An example of a questions and answers can be viewed at these websites:
http://wings.buffalo.edu/faculty/research/bioethics/dnr-p.html
http://www.health.state.ny.us/publications/1441/

About the author

I am currently completing my second year of the distance post RN BScN program at Laurentian University. I graduated from Algonquin College in 1997 and started working as a staff nurse at the University of Ottawa Heart Institute right away. I worked there until 2000 when I transferred over to the Ottawa Hospital Civic Campus emergency department. In 2007 I transferred back to the Heart Institute. I achieved the Emergency Nursing certificate from Algonquin College in 2005 and the Canadian Nurses Association Certification in 2008.

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outlook
NENA at work

One thing 30 years of nursing has taught me... "Learn to Catnap"

In September 2010, I attended the ENA Conference in San Antonio, Texas, and enjoyed the workshops immensely. One in particular that hit home was Fatigue: The Insidious Safety Hazard.

Fatigue, as it relates to lack of sleep, is something all emergency nurses will endure at some point in their career, whether sporadically or on a constant basis.

Early in my nursing career, working shift work with two small children at home and a husband who frequently worked out of town, my fatigue had reached a critical level. I was becoming clumsy, irritable and emotional at work, as well as with my family and friends. A coworker and mentor with many years of experience told me I needed to learn how to *catnap* or I was going to burnout. I remember saying, "Yeah, that's easy to say, but if I close my eyes I'm a goner for the night"! She explained to me that *catnapping* takes a little practice and she was willing to help me out. So, starting that very nightshift, I put my head down on the desk and closed my eyes. Sure enough, I was out like a light. Thirty minutes later, my mentor was shaking me and handing me a glass of water. At first I had a difficult time getting fully awake. However, after four nights of repeating this procedure, I actually woke up just before she shook me! It wasn't all clear sailing, but I did learn to take 30-minute catnaps on my breaks, at home before nightshifts or whenever I knew I was going to be awake for an extended period of time.

My advice to new nurses has always been:

1. **Learn about fatigue,** you cannot bank sleep, you can only work on catching up.
2. **Watch for signs of fatigue.** Tired people are more likely to make bad decisions and increase their risk of making mistakes or having accidents. As well, they come down with more medical conditions and catch more colds. We readily identify fatigue in our coworkers; however, we need to learn how to recognize it in ourselves.
3. **Find ways to reduce the effects.** Doing something to reduce the effects of fatigue helps you, your coworkers and your patients. My saving grace was learning to *"catnap"*.

There are many assessment tools and indicators for fatigue. One quick and easy one is: Multidimensional Assessment of Fatigue (MAF), **www.son.washington.edu/research/maf**

Sharron Lyons,
President-elect