UNDERSTANDING NURSING CARE OF OLDER ADULTS WITH ‘DO NOT RESUSCITATE’ ORDERS IN ACUTE CARE

by

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Abstract

In recent years, the use of DNR orders in acute care has been increasing, especially for older adults. Unfortunately, many nurses misinterpret the definition of DNR and this knowledge gap has implications for how care is provided for older adults. This lack of understanding of meaning as well as care practices associated with DNR designations is a cause for concern, as it has practical, ethical and moral implications for patient care. Nursing practice in relation to DNR orders can have permanent consequences on the health outcomes of patients and it is therefore essential to acknowledge and recognize the personal and contextual forces that shape the care of older adults with DNR orders in acute care so that ethical practice be supported.

This interpretive descriptive study explored nursing care of older adults with DNR designations on medical/surgical units in acute care and also identified facilitators and barriers towards their ethical practice in relation to DNR orders. Data were collected through semi-structured interviews with Registered Nurses (N=8) employed on acute medical units at an urban community hospital in British Columbia. Audiotaped interviews were transcribed and analyzed using an interpretive descriptive approach. Five main themes and 19 subthemes were identified.

The Registered Nurses indicated the need to clarify the interpretation of DNR in clinical practice and acknowledged the complexities of the DNR decision making process. The nurses emphasized that patients were given safe and ethical care irrespective of code status however nursing interventions were prioritized for full code patients. Nurses reported complex barriers to their ethical practice in relation to DNR order such as unrealistic physician orders, the lack of time in conjunction with the lack of knowledge of the patient’s wishes and highly directive and
anxious family members. Facilitating factors towards nursing care of DNR designated patients comprised of education which was viewed as essential in improving care practices and assessment skills for dying DNR designated patients. Team work, higher nurse to patient ratio and support were also associated with propelling better nursing care and practice. The themes have implications for nursing practice, administration, education, and research.
Preface

Ethics approval for this study was obtained from one Health Authority. The associated ethics numbers are as follows: University of British Columbia #H12-03151 and Fraser Health Ethics Approval-FHREB 2013-018.
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CHAPTER 1: PROBLEM IDENTIFICATION AND PURPOSE

1.1 Introduction

Globally, older adults represent the fastest growing segment of our society. In Canada, people aged 80 years and over have exceeded the 1 million mark; this growth is projected to last until 2036 where seniors will account for 25% of the total population (Canadian Institute for Health Information, 2011; Federation of Canadian Municipalities, 2013). As a result, older adults form the largest cohort in the care delivery of nurses. Older adults are the largest age segment utilizing the health care system by occupying 50% of acute care beds (Bednash, Fagin & Mezey, 2003; Higgins et al., 2007; Holroyd, 2009; Plonczynski, et al., 2007). Despite advances in diagnostics and community management programs older adults tend to have higher hospital admission rates and increased length of hospital stay (Higgins et al., 2007). Consequently, older adult patients have a higher risk of dying in hospital compared to younger patients (Canadian Institute for Health Information, 2011). This in part is due to the existence of multiple comorbidities, chronic conditions, pre-existing disability, reduced functional capacity and the aging process (Higgens et al., 2007; Plonczynski et al., 2007). Given such complexity, older adults challenge the acute care system with their complex health needs. The complexity of care is further intensified for health care providers such as nurses who practice in a highly structured health care environment which does not acknowledge the multifaceted needs of older adults (Chappell & Penning, 2001; Clarke, 2006; Plonczynski et al., 2007). Older adults do not meet the rigid industrial model of admission and discharge (Sellman, 2009). Nursing care and practice is enacted in environment with highly ingrained negative attitudes, and perceptions of older adults (Nelson, 2005; Wakefield & Holman, 2007). Do Not Resuscitate
As the Canadian population is rapidly aging with increasingly complex conditions, decisions regarding medical futility of hospitalized patients are becoming an important issue (Hohenleitner, 2002; Storch, Starzomski, & Rodney, 2013; Weiss & Hite, 2000). Medical futility is defined as “a medical treatment that is seen to be non-beneficial because it is believed to offer no reasonable hope of recovery or improvement of the patient’s condition” (Canadian Nurses Association, 2011). One of the ways decisions regarding medical futility are made is through the documentation of a “Do Not Resuscitate” (DNR) order (Storch, Starzomski, Rodney, 2013). DNR orders represent one of the many complex decisions in which patients and or families can refuse life prolonging interventions (Storch, Starzomski, & Rodney, 2013; Weiss & Hite, 2000). DNR orders are supposed to encourage advocacy for dying patients through the prevention of painful and futile treatments which may leave them dependent on artificial life support, lengthen the dying the process or decrease dignity during the last moments of life (Resnick, Cowart, & Kubrin, 1998; Storch, Starzomski, & Rodney, 2013). In this way, DNR orders may be a part of comfort care decisions (Resnick, Cowart, & Kubrin, 1998). Although the DNR order is considered one of the most significant patient directives because it has permanent and irreversible health consequences, much ambiguity surrounds its conceptualization which has led to ambiguity in end of life care interventions (Payne & Thornlow, 2008; Storch, Starzomski, Rodney, & 2013). This ambiguity is intensified because DNR is closely linked to comfort in end of life care decisions (Resnick, Cowart, & Kubrin, 1998). While, there are many variations about the meaning of DNR for the purpose of this study the term DNR will be defined as, “cardiopulmonary resuscitation (CPR) not be initiated at the time of a cardiac or respiratory arrest” (Thibault-Prevost, Jensen & Hodgins, 2000, pg, 259).
A broad range of medical practices have become associated with DNR which do not exclusively relate to withholding CPR under this legal definition (Jezewski, 1994; Thibault-Prevost, Jensen & Hodgins, 2000). These medical practices include the withdrawal, and or the overuse of specific interventions which have become associated with reduction in patient care quality. For example DNR in the clinical setting is often misapplied, with the result that either under treatment or over treatment occurs. This misapplication of treatment has occurred through withholding nutrition, hydration, blood work and appropriate monitoring of the patient (Mello & Jenkinson, 1998; Purvis et al., 2009; Thibault-Prevost, Jensen, & Hodgins, 2000). In some circumstances misapplication has occurred through the overuse of analgesics such as morphine sulfate to decrease respiratory effort (Mello & Jenkinson, 1998; Purvis et al., 2009; Thibault-Prevost, Jensen, & Hodgins, 2000). In this way, DNR becomes conflated with no treatment and no care. The definition of DNR also becomes misunderstood amongst health care professionals, families and patients creating conflict (Bellini & Damato, 2009, Jezewski, 1994). This conflict often arises when there are differences in opinion about the appropriateness of a DNR order for a particular patient, also about who should be involved in the decision making process and about the aggressiveness of treatment for the DNR designated patients (Jezewski, Scherer, Miller & Battista, 1993; Manias, 1998; Purvis et al., 1998; Sulmasy et al., 2008).

Adding to this complexity and conflict is the financial strain felt on the health care system post resuscitation. The cost of health care post resuscitation is remarkable especially in medically futile cases. This financial burden includes specialty drugs, bed occupancy in ICU, equipment, labor and ongoing care costs (Bishop et al., 2010; Hayward, 1999; Weiss & Hite, 2000). Economic resources invested in futile cases may not be considered effective utilization of
health care resources (Cordozo, 2005). Economic health care rationing can be linked to addressing DNR to the best interest of the patients in order to avoid futile, expensive and distressing advanced cardiac life support (Hayward, 1999; Weiss & Hite, 2000). Research indicates that older patients value quality of life and have an aversion to unnecessary life prolonging technologies yet aggressive treatment is provided to these patients at the end of life (Heyland et al., 2006; Lloyd, Neitert, & Silvestri, 2004). Clearly, there is a need to improve communication and decision making about life sustaining technologies with patients and families. This lack of communication leads to immense clinical and economic consequences (Storch, Starzomski, & Rodney, 2013). In addition; this can lead to under treatment when decisions are not made carefully. Inadequate communication and uniformed decision-making can lead to ethical dilemmas for health care professionals such as nurses about their legal, economic, moral, philosophical and clinical position about the feasibility and viability of resuscitation.

1.1.1 Nursing and Older Adults

As end of life care of older adults is increasingly occurring in acute care institutions, it is essential to examine nursing perceptions and attitudes towards older adults as they are forefront care providers. Perceptions and attitudes about older adults are influenced by several factors and are embedded within a relational context which includes nursing workload, nursing knowledge of the aging process (gerontological knowledge), personal values, attitudes and structure of nursing work culture (Gallagher, Bennett, Halford, 2006; McLafferty & Morrison, 2004; Pursey & Luker, 1995). Budgetary cutbacks and health care system reforms have had major repercussions on care delivery in acute care (Browne & Tarlier, 2008). These reforms have led to the closure of hospitals, reduction of acute care beds and changes in hospital practice settings and
health care provider roles (Geva-May & Maslove, 2000). Thus increased workload pressures combined with time constraints inhibits the formation of a quality patient to nurse relationship, reduces empathy and awareness of the patient’s holistic care needs as well as reinforce ageist views and attitudes (Higgins et al., 2007; Holroyd et al., 2009). In this way older adults are perceived as burdensome, requiring significant levels of resources and attention which confounds end of life discussions (Courtney, Tong, & Walsh, 2000).

Knowledge about aging and older adults influences quality of care delivery and practice in the acute care setting (Higgins et al., 2007; Holroyd et al., 2009; McLafferty & Morrison, 2004). Studies have found that nurses with a higher level of education and knowledge of older adults generally hold more positive attitudes towards caring for older adults (Armstrong-Esther, 1989; Hope, 1994, McLafferty & Morrison, 2004; Pursey & Luker, 1995). With focused older adult knowledge, nurses are able to effectively formulate patient centered care plans, able to better advocate for their patient needs and direct their assessment and observation skills with increased accuracy (Courtney, Tong & Walsh, 2000; Holroyd et al., 2009; Pursey & Luker, 1995).

Personal beliefs, values and attitudes define and shape how individuals interact, communicate and behave towards older people (Marshall, 2010; Phelan, 2011). An individual’s personal experiences and beliefs about their own aging and future aspirations all influence attitudes (Alabaster, 2007). Negative attitudes can lead to ageism. Ageism is defined as a “process of stereotyping and discriminating against someone because they are ageing or aged” (Marshall, pg. 96). Ageism extends beyond biomedical discourses and also involves relations of power and inequality, which confounds DNR decisions (Phelan, 2011). These negative attitudes
towards older adults and ageist views not only influence quality of care but also professional socialization of students and new nurses (Gallagher, Bennett, & Halford, 2006; McLafferty & Morrison, 2004; Soderhamm, Lindencrona, & Gustavsson, 2001). Nursing students are socialized to view caring for older adults as heavy, monotonous, boring, a waste of time and resources. Furthermore, nurses who care for older adults are also stigmatized and thought of as working below their training and skill level (Alabaster, 2007; Marshall 2010; McLafferty & Morrison, 2004). Ageist views and stereotypes cluster older adults into a homogenous group where routine and task orientated approaches are implemented rather than patient centered approaches (Marshall, 2010).

The structure of nurses’ work environments impacts older adult care and experiences. Health care environments that highly emphasize routines and efficiency based nursing practices promote production over quality care (Pursey & Luker, 1995; Weiss, Malone, Merighi, & Benner, 2002). Consequently, patients are propelled along a set trajectory where they are treated as quickly and inexpensively as possible (Pursey & Luker, 1995; Weiss et al., 2002). Work environments where production, efficiency, and cost containment trump quality of care promote negative stereotypes and ageist views of older adults. These include beliefs that older adults are helpless, cognitively diminished, burdensome, incontinent and dependent (Higgins et al., 2007; Marshall, 2010). Negative nurse perceptions strongly influence care provided to older adults as well as recovery rates (Holroyd et al, 2009; McLafferty & Morrison, 2004).
1.2 Significance

Clearly nursing attitudes, experiences and perceptions of older adults are influenced by a combination of complex contextual factors which include the complex socio-political climate of the health care system. The highly stressful environment of the health care system drives nurses to be efficient, to have multiple role responsibilities, and confront critical care situations with limited and declining resources. This environment shapes nurse’s beliefs, attitudes and perceptions of quality of life issues and it may shape their responses to end of life situations. Not only do these attitudes and perceptions have a significant effect on care delivery and patient outcomes but can play a major role in proliferation of ageist views as well as negative socialization of new nurses. Unfortunately, these attitudes and perceptions of older adults may influence the interpretation of DNR orders. DNR orders exclusively direct health care providers to forgo cardiopulmonary resuscitation. These orders do not encompass the withdrawal of appropriate monitoring and assessment of patients or treatment interventions (Resnick, Cowart, & Kubrin, 1998). DNR orders allow patients to exercise control over treatment modalities at the last days of life. Since, DNR is closely linked to comfort care and the right to die with dignity much ambiguity surrounds its understanding and conceptualization. The difference between DNR orders and other limitations of medical treatment become blurred. Consequently, health care providers erroneously understand DNR status to imply that a patient is dying and should not ever undergo life saving interventions (Fritz, Fuld, Haydock, & Palmer, 2010).

There have been several studies that indicate that physicians believe that DNR patients should receive less aggressive treatment. Patients with DNR orders were less likely to be transferred to the ICU, receive blood transfusions, blood cultures drawn and undergo central line
placements (Beach & Morrison, 2002; Bedell et al., 1986; Cohn et al., 2013; Keenan & Kish, 2000). DNR orders have also been associated with a decrease in the number of physician orders, physician visits, chart entries and diagnostic testing (Beach & Morrison, 2002; Bedell et al., 1986; Cohn et al., 2013; Keenan & Kish, 2000). In addition, the presence of DNR orders have also been associated with less aggressive nursing care. Several studies have shown that nurses thought that less physical care should be given to DNR patients including weighing patients, drawing blood cultures and completing physical assessments. In addition, nurses were less likely to notify physicians of changes in urine output and hypotension (Henneman et al., 1994; Sherman & Branum, 1995; Thibault-Prevost, Jensen, & Hodgins, 2000). Although, the withholding of acute treatment may be what the patient or family want, the literature indicates that it can go beyond what they have requested or is in their best interests due to misunderstandings and misconceptions surrounding DNR.

It is well recognized in the literature that older adults are more likely to receive DNR orders than younger patients. Regardless of prognosis, increasing age and the presence of DNR orders are positively correlated (Boyd et al., 1996; Chang, Huang, & Lin, 2010; Cherniack, 2002; Hamel et al., 1999; Hakim et al., 1996). Evidence also suggests that physicians consider advanced physiological age as an essential factor in determining the aggressiveness of treatment of their patients (Ebell, Doukas, & Smith, 1990; Mello & Jenkinson, 1998). DNR orders and advanced age have also been shown to be associated with less aggressive nursing care (Henneman et al., 1994; Shelley, Zoharchak & Gambrill, 1987). This indicates that assumptions and stereotypes about DNR and end of life care preferences are frequently made by health care professionals on the behalf of their patients which may not be entirely representative of the
patients’ wishes. These assumptions and stereotypes influence the quality of care and specifically nursing care of patients with DNR orders.

Research suggests that during a cardiac or respiratory arrest in hospital, nurses are the first health care professionals on site; they are either required to begin cardio-pulmonary resuscitation or withhold it (Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). Nurses encounter moral and ethical dilemmas when clear and appropriate communication, documentation, consultation with the patient and family is lacking about resuscitation status (De Gendt et al., 2007; Schultz, 1997). In addition to this, nursing attitudes and possible ageist views towards older adults and DNR influences practice and aggressiveness of treatment (Jezewski, 1994; Shelley, Zoharchak, & Gambrill, 1987). Care of older adults may become compromised and health care opportunities denied (Marshall, 2010).

It is apparent the term DNR is often misunderstood and misapplied by nurses in acute care. This lack of understanding of meaning and misapplication of treatment associated with DNR designations is a cause for concern, as it has practical, ethical and moral implications for patient care. Therefore, understanding nurses’ care experiences provides opportunities for nurse educators as well as nursing educational programs to evolve to meet the challenges associated with caring for older adults with a DNR status in acute care. In addition, better understanding of nursing experiences will highlight the complexity of practice constraints which may provide impetus for further nursing training, information workshops and improved communication surrounding DNR as well as future policy work related to end of life. Nursing practice in relation to DNR orders can have permanent consequences for the health outcomes of patients. It is
therefore essential to acknowledge and recognize the personal and contextual forces that shape the care of older adults with DNR orders in acute care so that ethical practice can be supported.

In summary, gaining an understanding of the nursing care of older adult patients in acute care with a DNR status is important to determine. This understanding will promote positive changes in care delivery and future socialization and professionalization of new nurses and combat societal influences of ageism (Lookinland & Anson, 1995). Increased knowledge will be beneficial in the development of education programs for nurses at both organizational and personal levels along with promoting a better understanding of the diversity in the older adult population in terms of their end of life care (Higgins et al., 2007). This enhanced understanding will benefit the care of older adults with a DNR status.

1.3 Problem Identification

Our overall understanding of acute care nurses in relation to their nursing care of older adult patients with a DNR status in hospital settings is insufficient. Medical and surgical nurses (medical/surgical) are of a particular interest as they are the frontline staff and frequently provide care for older adults with multiple complex health care conditions. The purpose of this study is to gain a greater understanding of medical/surgical nurses’ care practices of older adults with DNR orders. Understanding their nursing care is important to improve older adult patient care quality, provide recommendations for policy, education and practice and possibly to help dispel negative attitudes towards older adults with their end of life care.
1.4 Statement of Purpose

The purpose of the study is to extend our understanding of nursing care of older adults with DNR designations on medical/surgical units in acute care.

1.5 Guiding Research Questions

1. How do nurses define DNR?
2. What do nurses view as the role of the Registered Nurse (RN) in relation to DNR status?
3. How does the context of acute care influence nursing care of older adults with DNR designations in medical/surgical units?
4. What do nurses see as barriers and facilitators to their ethical practice related to DNR orders?
5. Based, on research questions #1 to 4, what are the implications for nursing practice with older adults who have a DNR designation?

1.6 Chapter Summary

In this chapter I have explained the background and significance for my research study. I have explained the problem statement and presented research questions guiding my study. The following chapter provides a synthesis of the current literature on nursing attitudes towards older adults and end of life care. In addition literature on DNR and nursing will be presented.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In this chapter, I present a review and synthesis of relevant literature to outline the context for my research study. The literature review includes an analysis and synthesis of current literature on acute care nurses’ attitudes towards older adults, death/dying as well as nurses knowledge and attitudes towards DNR, nurse’s practice in relation to DNR and acute care as a context for end of life care for the older adult.

2.1.1 Inclusion Criteria for Selection of Studies

Both qualitative and quantitative studies were selected and included in the literature review. Experimental designs with control and intervention groups as well as non-experimental design studies were included. These consisted of survey/questionnaire studies that were descriptive, correlational and exploratory in nature. Qualitative studies were included in the review to gain a deeper and more detailed understanding of the nurses’ attitudes and experiences towards older adults, do not resuscitate and death.

Since a large part of the literature on DNR decision making, older adults, end of life care and nursing attitudes relates to long term care, palliative and hospice care, only studies that related to hospital or acute care settings, adult patients and research that focused on acute care nurses were included. Studies that related to acute care settings and acute care nurses were focused upon because they were highly relevant to my research inquiry and it was assumed that the setting characteristics were important to the research analysis and interpretation. The publication dates of the research articles as well the origin country of the study were not
specified as inclusion criteria. Studies conducted in the English language were included in the criteria and only peer reviewed articles were used for credibility and quality purposes.

2.1.2 Identification of Studies

Five major databases CINAHL, Pubmed, Psycinfo, Academic Search Complete, Web of Science were used to identify the studies. Keywords used to initially conduct the search included the phrase “Do Not Resuscitate” along with the abbreviation DNR, older adults, death and dying. Keywords such as resuscitation, hospital and acute care were also applied. Additional search terms were used after exploring MESH headings and subject headings; these included nursing perceptions, attitudes, advance directives, nursing decision-making and experiences.

2.2 Review of Current Evidence

2.2.1 Do Not Resuscitate (DNR)

Addressing the code status of hospitalized patients is an important issue, especially as the population continues to age and as more patients are dying in acute care (Hohenleitner, 2002; Payne & Thornlow, 2008; Weiss & Hite, 2000). In this way, the Do Not Resuscitate (DNR) order is considered to be one of the most significant patient care directives. The DNR order strongly influences care practices and is associated with permanent and irreversible health consequences (Payne & Thornlow, 2008). Although, the term DNR has many variations in meaning, the legal definition of DNR in Canada is that cardiopulmonary resuscitation will not be commenced in the event of a cardiac or respiratory arrest (Thibault-Prevost, Jensen, & Hodgins, 2000).
Unfortunately in acute care, specific medical practices have been attached to DNR that have obscured its legal definition (Bellini, & Damato, 2009; Jezewski, 1994; Thibault-Prevost, Jensen & Hodgins, 2000). These practices are a result of an over interpretation of the meaning of DNR as well as DNR being extended as a plan of care (Murphy & Price, 2007; Stewart, & Baldry, 2011; Storch, Starzomski, & Rodney, 2013). For example, limiting the use of antibiotics to treat infections such as urinary tract infections. The misapplication of care practices with DNR has led to conflict amongst health care professionals, and has created ethical and moral dilemmas regarding aggressiveness of treatment (Jezewski, Scherer, Miller, & Battista, 1993; Manias, 1998; Purvis et al., 1998; Sulmasy et al., 2008). Conflicts have arisen due to notions of financial strain regarding post resuscitation in futile cases. Thus, questions relating to feasibility and viability of resuscitation often have been raised creating moral, ethical, clinical and philosophical dilemmas for health care professionals specifically nurses.

In recognition of these ethical dilemmas and conflicts, standardized DNR policies have been implemented by many health care institutions in order to execute safe and effective clinical practice. DNR policies have been formulated to improve the meaning and understanding of DNR orders and are intended to assist health care professionals in carrying out the desired care practices (Bellini & Damato, 2009). Ultimately, DNR policies aim to support patient autonomy in exercising control over their end of life decisions (Giles & Moule, 2004). Thus DNR policies should contribute to improved standards of health care delivery (Manias, 1998; Storch, Starzomski, & Rodney, 2013).
2.2.2  *Attitudes towards DNR and the Understanding of DNR Policies*

Due to the variations in meaning of DNR and the surrounding ambiguity in interpretation, it is important to understand the attitudes of acute care nurses towards DNR. Attitudes towards DNR orders are important to identify and recognize as they highly influence care practices, socialization of new nurses and most importantly the holistic health of patients. As the use of DNR orders have increased for older adults in acute care, it is essential to examine and explore the surrounding attitudes, knowledge bases and perceptions.

2.2.2.1  *Nurse Knowledge of DNR*

A common theme that emerged across the studies on acute care nurses’ knowledge of DNR is the lack of a clear understanding in meaning, application as well as the lack of knowledge of DNR policies (Jepson, 2003; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). Studies have shown that DNR is misunderstood by nurses in acute care (Fritz, Fuld, Haydock, & Palmer, 2010; Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen & Hodgins, 2000). For example, a Canadian study done on the perceptions of critical care nurses regarding DNR decisions, indicated that only 48.6% of the nurses were able to correctly define DNR under its legal definition and 52.6% failed to identify between DNR and other care practices associated with end of life decisions (Thibault-Prevost, Jensen, & Hodgins, 2000). In this way, DNR is often broadened and misused either incorporating or eliminating treatment depending on the understanding of the DNR order. In a Finnish study examining nurses experiences and views on end of life decisions, results indicated that 44% of nurses associated DNR with partial or
complete palliative care (Hilden, Louhiala, Honkasalo, & Palo, 2004). Although, the response rate for the questionnaire this study was low, the findings are alarming as it clearly showed that patients may not be receiving safe and appropriate care.

2.2.2.2 Nurse Awareness of Policies

This lack of understanding of meaning as well as care practices associated with DNR designations is a cause for concern, as these influence the initiation, continuation and the withdrawal of nursing and medical interventions (Bellini & Damato, 2009; Cohn et al., 2013; Fritz, Fuld, Haydock, & Palmer, 2010; Stewart & Baldry, 2011; Thibault-Prevost, Jensen, & Hodgins, 2000). Not only does this lack of knowledge and understanding have physical consequences for patients, but they also have ethical and moral implications for patient care. McAdam, Barton & Rai (2005) further discussed these misconceptions as significantly comprising the wishes and rights of patients. For example, patients are in danger of not receiving aggressive treatment even though they may medically benefit and desire active ongoing treatment. This draws attention to, the reality that DNR designated patients may be receiving less medical and nursing care as compared to patients who do not have a DNR order in place. In addition, two qualitative studies have shown how misunderstandings about the meaning of DNR orders have led to negative interpersonal and intrapersonal conflicts amongst health care professionals, patients and family members (Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994). These types of discrepancies only serve to jeopardize safe and effective care.
Along with the misconceptions associated with the DNR order, nurses in acute care are also often unaware of the existence of DNR policies in their particular health care organization (De Gendt, 2005; Duke & Thompson, 2007; Jepson, 2003; Manias, 1998; Smith, Poplett, & Williams, 2005; Thibault-Prevost, Jensen, & Hodgins, 2000). In Manias’ (1998) study of Australian acute care nurses, findings indicated that out of 103 nurses from 2 hospitals with a DNR policy, less than half (45.6%) were aware of the existence of a DNR policy. This is a reason for concern, without the awareness of policies and practice guidelines quality care cannot be implemented. Smith, Poplett, & William (2005), further explain that insufficient knowledge of DNR policies promotes inaccuracy in communication with patients and next of kin, leading to inappropriate medical management. Although the majority of the nurses were not as knowledgeable of DNR policies in their institution, they did specify that unit specific DNR polices would support better nursing practice (De Gendt, 2005; Jepson, 2003; Manias, 1998; Smith, Poplett, & Williams, 2005; Thibault-Prevost, Jensen, & Hodgins, 2000). Despite such challenges, in general acute care nurses support and encourage the development of DNR policies in their institution (Giles & Moule, 2004; Jepson, 2003; Thibault-Prevost, Jensen, & Hodgins, 2000).

While nurses support the formation of DNR policies in their institutions and accept that polices contribute to better standards of care, nurses on the whole are not involved in the policy making process (Duke & Thompson, 2007; Giles & Moule, 2004; Manias, 1998; Sulmasy et al. 2008; Thibault-Prevost, Jensen, & Hodgins, 2000). According, to Giles and Moule (2004) nurses need to play a significant role in shaping as well as implementing DNR policies. This role
enhances impact on the DNR decision, patient care and nursing autonomy. While policies provide guidelines for decision-making surrounding DNR, they also standardize practice, promoting superior standards of care for both patients and their families (Giles & Moule, 2004).

Even though nurses may or may not be involved in the DNR decision for their patients, they are left with the implications and responsibility caring for patients and their families. On the whole, nurses in acute care support DNR orders, advance directives and living wills, especially when desired by the patient or family (Duke & Thompson, 2007; Ganz, Kaufman, Israel, & Einav, 2013; Giles & Moule, 2004; Hilden, Louhiala, Honkasalo, & Palo, 2004; Jepson, 2003; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). For instance, three studies examined nurse’s attitudes concerning the aggressiveness of care of terminally ill patients (Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). In particular, respondents in Thibault-Prevost, Jensen, & Hodgins (2000) study of Canadian critical care nurses believed that when quality of life was poor after CPR, DNR orders were written for patients. Consequently, findings from the same study indicated that, 72% of nurses agreed that aggressive therapy should not be initiated for patients with a DNR status. Sixty five percent of nurses perceived ICU admissions as inappropriate for DNR designated patients.

Nurses across the studies felt nursing care should be maintained for DNR designated patients (Giles & Moule, 2004; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Thibault-Prevost, Jensen, & Hodgins, 2000). Similarly, the results from Jezewski, Scherer, Miller’s & Battista’s (1993) qualitative study suggested that nurses did not associate do not resuscitate with “do not care”. Although, the participants in this study were primarily critical care
nurses, the themes that emerged demonstrated that the experiences of nurses caring for DNR patients and families are diverse.

The attitudes of nurses revealed the importance given to patient and family involvement in the DNR decision-making process (Giles & Moule, 2004; Hilden, Louhiala, Honkasalo, & Palo, 2004; Jepson, 2003; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). In two qualitative studies nurses described aspects of their professional responsibility which included patient autonomy, dignity and informed decision making during the DNR decision process (Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994). Researchers from both studies discussed the importance of timing of the DNR discussion to prevent possible coercion and conflict (Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994). DNR discussions should occur when patients can appropriately exercise their judgment to confirm their wishes and values prior to a critical incident (Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994). Even though, these two studies highlighted the importance of nurses roles in the DNR decision making process in supporting patients and their families there are methodological weaknesses in the research. These methodological weaknesses include the lack of researcher reported member checking, triangulation and bracketing.

The influence of nurses’ attitudes, experiences and area of practice on DNR decision-making was examined in two studies (Giles & Moule, 2004; Manias, 1998). Researchers Giles and Moule (1998) compared nurse’s attitudes towards and experience of DNR decision making with five variables (age, grade-novice to advanced, years of nursing, area and length of experience on unit). The overall results indicated that there was no significant difference found
between nursing attitudes and these five variables. However, the findings did suggest that acute/general medical nurses had more positive experiences with DNR decision-making than nurses who worked in surgical/neurosurgical, trauma care and orthopaedics. These findings also parallel findings from Manias’ (1998) study where ICU nurses considered themselves as less successful in influencing DNR decisions compared to nurses who worked in the acute medical and surgical areas. This is partly due to the differences in care philosophies as the intensive care paradigm focuses on maintaining survival and overcoming death at all odds.

2.2.2.4 Nurse Practices in Relation to DNR Decisions

Nursing practice in relation to DNR decisions can have permanent consequences on the health outcomes of patients and therefore are critical to examine. I was able to find only one study that examined nurse’s adherence rates to DNR decision-making (De Gendt et al., 2005). This study found that CPR was not initiated for those patients that had a designated DNR order and that nursing practice complied with the specific outlined directive.

Whilst nurses believe that care should be maintained for DNR designated patients, some studies suggest that the presence of DNR orders have been shown to be associated with less aggressive nursing care (Cohn et al., 2013; Fritz, Fuld, Haydock, & Palmer 2010; Henneman et al., 1994; Sherman & Branum, 1995; Stewart & Baldry, 2011; Thibault-Prevost, Jensen, & Hodgins, 2000). Some studies have shown that nurses thought that less physical care should be given to DNR patients including weighing patients, drawing blood cultures and completing physical assessments. In addition, nurses were more passive to notify physicians of changes in urine output and hypotension (Henneman et al., 1994; Park, Kim, & Kim, 2011; Sherman &
Branum, 1995; Thibault-Prevost, Jensen, & Hodgins, 2000). In their study, Stewart and Baldry (2011) found a reduction in the urgency that nurses displayed in re-assessing a deteriorating patient following the implementation of a DNR order. The results of these studies indicate an over interpretation of the DNR order as a method of care and the discontinuation of certain medical interventions. Similarly, Fritz, Fuld, Haydock, and Palmer (2010) found that nurses believed that a DNR reduced, medical escalation which meant moving patients to a more acute level of care units, contacting the outreach team and frequency of nursing observations. In addition, the results of their study also showed that doctors believed that those with DNR orders should have reduced referrals to medical and outreach teams. The findings of these studies indicate that patients with DNR orders may be receiving substandard care. Although, reduced treatment can be consistent with patient and family wishes, the critical issue relates to the uncertainty and misperceptions surrounding the appropriateness of reduced treatment.

Studies across the literature highlighted the lack of nursing involvement and clearly defined roles in the DNR decision making process (Ganz, Kaufman, Israel, & Einav, 2013; Giles & Moule, 2004; Hilden, Louhiala, Honkasalo, & Palo, 2004; Jepson, 2003; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). Themes throughout these studies revealed that nurses desired an active role in DNR decisions (Giles & Moule, 2004; Hilden, Louhiala, Honkasalo, & Palo, 2004; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000, Thompson, 2007). The majority of nurses voiced frustration and disappointment in how DNR decisions occurred without their participation as well as how discussions were only initiated by physicians. Their lack of consultation or involvement was perceived to disregard
their experience, knowledge and understanding of the patients and families wishes. Even though, nurses spend a considerable amount of time at the bedside, nurses in these studies felt that their knowledge was not recognized by physicians (Ganz, Kaufman, Israel, & Einav, 2013; Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). This was also seen as a major impediment in patient advocacy.

### 2.3 Summary of DNR

It is clear that nurses have limited participation in the DNR decision for their patients and may be largely unaware of the details of the DNR policies specific to their institution (Ganz, Kaufman, Israel, & Einav, 2013; Jepson, 2003; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). In addition, the studies revealed a general ambiguity in the meaning and interpretation of the term DNR (Fritz, Fuld, Haydock, & Palmer, 2013; Jezewski, Scherer, Miller, & Battista, 1993; Manias, 1998; Mello & Jenkinson, 1998; Stewart & Baldry, 2011; Thibault-Prevost, Jensen, & Hodgins, 2000). Due to this ambiguity, combined with the lack of nursing involvement in the DNR decision, education is required to address this critical issue at a larger scale. Health care institutions need to provide education, workshops, and counseling sessions in order to assist nurses to understand the DNR process (Payne & Thornlow, 2008). Improving nurse knowledge promotes the development of insight and appreciation of medical interventions and ultimately aids achievement of patient care goals (Bellini & Damato, 2009; Duke, & Thompson, 2007; Ganz, Kaufman, Israel, & Einav, 2013; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000).
According to Manias (1998), nursing impact on DNR decisions will be enhanced by increasing nurse involvement in policy formation and evaluation. Policies need to be flexible which allow nurses to utilize their clinical expertise to evaluate specific end of life cases and circumstances which are both unique, distinct and require individual attention. This intimate involvement provides motivation for acknowledging and addressing DNR conflicts and empowers nurses to bring their practice related concerns to the appropriate institutional directives as committed patient advocates (Bellini & Damato, 2009; Manias, 2008). On the large scale, this permits nurses to address institutional constraints that negatively influence patient outcomes and to uphold a highest degree of health care delivery.

Despite the prevalence of DNR orders, few studies have focused exclusively on medical/surgical nurses’ practice experiences with older adults who have DNR designations. Much of the literature focuses on attitudes of medical professionals such as nurses and physicians in critical care environments in relation to DNR orders, their role in the DNR decision and practices associated post DNR orders. Consequently, there is a need to examine medical/surgical nurses practice experience with older adults who have an existing DNR status.

2.4 Acute Care Nurses Perceptions and Attitudes towards Older Adults

Attitudes are a learned tendency to understand, organize and evaluate the world in a specific manner. Attitudes also have a strong influence on behavior and knowledge acquisition (Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009). In the context of my study, it is important to understand the attitudes that acute care nurses hold towards older adults as attitudes influence nursing practice. In addition, these attitudes are necessary to understand as they shape the
nursing care of DNR designated older adults in an acute setting. Therefore, in the following sections, I examine nursing attitudes towards older adults and nursing attitudes towards death/dying in acute care.

Quantitative, qualitative and mixed methods studies have been conducted to date on acute care nurses attitudes towards older adults. I have included literature from a 20 year period which may have influenced my interpretation and contextualization of nursing attitudes towards aging in relation to my study. The literature indicates that nursing attitudes towards older adults are shaped by societal myths and stereotypes. These societal myths and stereotypes regarding aging and the aged are known as Ageism (Brocklehurst & Laurenson, 2008; Butler, 1969; Higgens, Van Der Riet, Slater, & Peek, 2007; Holroyd et al., 2009; Palmore, 2001). Studies have shown that nurses hold varying positive and negative attitudes towards older adults (Courtney, Tong, & Walsh, 2000; Furlan, Craven, Ritchie, Coukos, & Fehlings, 2009; Gallager, Bennet & Halford, 2006; Higgens et al., 2007; Hope, 1994; Jacelon, 2002; McLafferty & Morrison, 2004; Pursey & Luker, 1995).

Most studies have examined relationships between organizational or practice area characteristics and gerontological education (Barba, Hu, & Efird, 2011; Carter, & MacInnes, 1996; Courtney, Tong, & Walsh, 2000; Gallager, Bennet & Halford, 2006; Hope, 1994; Soderhamm, et al., 2001). The themes presented in the literature regarding attitudes strongly correlate with area of practice, professional educational and nursing biological age (Armstrong, Sandilands, & Miller, 1989; Carter & MacInnes, 1996; Courtney, Tong, & Walsh, 2000; Gallager, Bennet, & Halford, 2006; Hope, 1994; Pursey & Luker, 1995). In one such study, Hope (1994) investigated nurse’s attitudes towards older adults in several different care settings. Findings
revealed that nurses who worked in acute elderly care areas rather than general practice areas held more positive attitudes. Results also suggested that older nurses and nurses with additional gerontological education had more constructive attitudes. Although the sample size was small (n=76) and convenience sampling was utilized, the researcher identified how aging is perceived and negatively constructed in society. This study identified the benefits of specialized geriatric education but also pointed out how this high degree of specialization can impair the process of integrating older adult knowledge into mainstream nursing care and practice.

Courtney, Tong and Walsh (2000) explored rural and metropolitan practice area nurses attitudes and practices towards older adults in their pilot study. Major differences between rural and metropolitan area nurse practices and knowledge levels were found on issues relating to hospital activity, post-operative complications, restraint usage and pharmaceutical awareness. In general both groups reported positive attitudes towards older adults however metropolitan area nurses emphasized the benefits of acute geriatric units. The researchers emphasized the importance of how the health care institution, the volume of patients accessing health services and allied health and discharge support can also influence nursing perspectives and practices. The authors hypothesized that results may have been influenced by geography, hospital size and community supports.

Scholars have suggested that attitudes and perceptions towards older adults influence health care delivery (Helmuth, Lookinland, Anson, & McCabe. 1995; Higgens, Van Der Riet, Slater, & Peek, 2007; Hope, 1994; Armstrong, Sandilands, & Miller, 1989). Helmuth et al. (1995) examined nursing attitudes in relation to restraint usage. Findings showed that nurses who self-reported as holding negative attitudes were more likely to use restraints and stereotype older
adults. Likewise, Armstrong, Sandilands, & Miller (1989), demonstrated that nurses who valued engaging in conversations and listening to patients held more positive attitudes than those who valued basic nursing care activities such as toileting and bathing. Likewise, Higgins and colleagues (2007) examined health care workers perceptions of hospitalized older adults. Their analysis revealed themes of “marginalisation”, “oppression of older people” and “stereotyping”. They also provided examples of how communication with older adults was poor, and requests for help were delayed. The findings indicated that nurses viewed that care for older adults was heavy, more time consuming than for younger patients, and a “waste of time” pg. 233.

Although, this study provided a thorough examination of the negative attitudes towards older adults it did not provide insight into the larger contextual tensions that exist for nurses caring for older adults. According to Carter & MacInnes (1996), attitudes play a significant role in nurses’ decision making approaches. In their study they assessed changes in ward and community nurse’s attitudes following the introduction of a program that required a new approach to decision-making involving the long term care of dependent older adults. Prior to the program, it was perceived that ward nurses preferred the continuation of hospital care of dependent older adults instead of community-based care. Following the introduction of the program, significant changes occurred in medical nurses’ attitudes from a “professional” (doctor/nurse) approach to a patient centered “patient choice” approach in relation to the care and placement of elderly patients who are at risk of continuing hospital care. The authors hypothesized that the intervention program helped overcome attitudinal stereotypes regarding patient input and capabilities of dependent elderly patients. Results of this study demonstrate that education based interventions can influence practice changes in discharge planning of older adults and reconstruct attitudes.
Research suggests that nurses who have higher levels of professional education and more knowledge about aging have more positive attitudes towards older adults (Armstrong-Esther, Sandilands, & Miller, 1989; Furlan, Craven, Ritchie, Coukos, & Fehlings, 2009; Gallager, Bennet & Halford, 2006; Hope, 1994; Soderhamn et al., 2001). In their study, researchers, Gallager, Bennet and Halford (2006) assessed the attitudes of Irish health care personnel including nurses, assistant personal and porters. Significant differences were found in negative attitudes between assistant personal, porters and nurses. Higher educational levels and increased training were shown to be predictive of lower negative attitudes. Influencing factors such as varying role responsibilities, time spent with older adults, as well as the health care institutions’ acknowledgement of negative attitudes were identified. Education and training were clearly recognized as the driving forces in combating negative attitudes towards older adults for all health care professionals. Scholars Furlan et al. (2009) examined the attitudes among Registered Nurses caring for older adults with spinal cord injuries in both an acute care unit and rehabilitation center. Their questionnaire-based survey revealed that nurses working in acute care held more ageist attitudes than their rehabilitation nursing counterparts. In addition, a higher level of education and working on the rehabilitation unit was associated with fewer ageist attitudes. Furlan et al. (2009) did emphasize that other factors such as age, frequency of caring for older adults with spinal cord injuries and nursing experience can also influence attitudes. However, in their study nursing education was significantly associated with more positive attitudes.

Nurses who prefer to work in specialty areas were seen to hold more positive attitudes towards older adults (Armstrong-Esther, Sandilands, & Miller, 1989; Barba, Hu, & Efird, 2011;
Hope, 1994; McLafferty & Morrison, 2004; Prevost et al., 1991). In their study Prevost et al., aimed to identify acute care nurses knowledge and attitudes towards older adults. Their results indicated that intensive care nurses had higher knowledge and more positive attitude scores than medical-surgical nurses. According to Armstrong-Esther, Sandilands, and Miller (1989) nurses who prefer to work in geriatrics and rehabilitation held more positive attitudes than those who chose to work in surgical units with patients under the age of 65 years of age. Likewise, Hope (1994) also demonstrated that those nurses who worked in acute elderly practice areas conveyed more positive attitudes compared to those nurses who practiced on general medical units. The personal preferences and characteristics of nurses who select specialized geriatric units or acute elderly care wards as work environments were offered as explanations for their overall positive attitude.

Not only does the type of practice area influence attitudes towards older adults, but the structure and organization of the care environment contributes as well. Care environments that focus on routine tasks, efficiency and technological adeptness create negative behaviors and attitudes that divert attention from patient-centered care (Barba, Hu, & Efird, 2011; Helmuth et al, 1995; Higgen et al., 2007; Jacelon, 2002; Lookinland & Anson, 1995; MacLafferty & Morrison, 2004; Pursey & Luker, 1995). This is more apparent in acute care settings, where nurses focus on routine observations, medication delivery and technical activity but may not always be conscientious of the fundamental hygiene, nutrition, elimination and educational needs of older adults (Higgins et al., 2007). The demands of the institution’s guidelines and the lack of a supportive work environment prevents nurses from developing positive attitudes that relay dignity, attentiveness and concern towards their older adult patients (Jacelon, 2002). Scholars
also suggest that chaotic contexts of acute care also play a major role in nurse’s ability to exercise autonomous decision making regarding the care of their patients (Barba, Hu, & Efird, 2011; Storch, Starzomski, & Rodney, 2013). Not only does this undermines quality of care but also prevents the individualization of care, ultimately propelling frustration, marginalization and stereotyping of older adults (Jacelon, 2002).

Although there are many positive attitudes reported towards older adults, negative attitudes and stereotypes are also described in the literature. Older adults are seen as a burden to the health care system, cantankerous, unable to adjust easily to their environment, possessing low skills and health, and requiring more physical care than their younger counterparts (Marshall, 2010; Lookinland & Anson, 1994). Caring for older adults in acute care is often seen as monotonous and a waste of time. Nurses who spend time interacting with their older patients are viewed by their colleagues as lazy and working below their training (Higgins et al., 2007; Marshall, 2010). Interactions with older adults are associated with laziness. Higgins et al. (2007) explains how older adults are marginalized and stereotyped via the way they are disregarded, ignored and spoken to and about by nursing staff.

2.4.1 Implications of Attitudes towards Older Adults

Implications of negative attitudes and stereotypes on the socialization process of new nurses and students are significant. Although, some studies indicate that nurses hold positive attitudes, new nurses are still socialized into a nursing culture where ageist attitudes and negative stereotypes are overtly and covertly enmeshed (MacLafferty & Morrison, 2004). New nurses are often pressured into assimilating to ward routines and care practices that may include sub-
standard practice towards older adults (MacLafferty & Morrison, 2004). These negative attitudes and stereotypes influence care as older adults continuously reported the lack of information given to them by health care professionals regarding their discharge planning, illness, recovery and quality of life (Courtney, Tong, & Walsh, 2000).

In spite of this, to break the cycle of marginalization nurse educators and staff nurses must share the responsibility of developing of nursing care for older adults (Soderhamn, et al., 2001). Nursing educators and frontline nurses need to be aware of their influence and to critically examine the existence of knowledge gaps about the aging process (Higgins et al., 2007; MacLafferty & Morrison). As nurses increasingly face caring for an aging population, they must raise their critical and political consciousness to prepare current and future nurses to provide care that safe and competent to this vulnerable population.

The care of older adults is threatened by specific negative attitudes and the socialization process of new nurses, ageist perspectives and lack of knowledge of the aging process. Medical-surgical nurses were seen to have major shortfalls in their knowledge of the aging process which influences quality of care (Courtney, Tong, & Walsh, 2000; Hope, 1994). Although, the implications for care are enormous, there is little awareness of the physiological changes, including sensory and physical changes, discharge needs and their risk for social isolation for older adults (Courtney, Tong, & Walsh, 2000). This brings to question whether older adults are receiving substandard care in the acute setting as these nurses may not possess in depth gerontological knowledge.
2.4.2 Summary of Attitudes towards Older Adults

In general the research does indicate that nurses in acute care hold varying positive and negative attitudes towards older adults. Higher levels of professional education, gerontological knowledge, and practice areas were seen as highly influential on nursing attitudes. The repeated themes throughout the literature relate to how health care institutions do not support the care of hospitalized older adults and the challenges nurses encounter caring for older adults within this environment. In addition, findings from the literature also suggest that negative nursing beliefs, ingrained ageist stereotypes and perceptions of older adults can be challenged through awareness on the behalf of policy makers and nursing educators. Nurse educators and staff nurses can help dispel prevailing attitudes and to shape the socialization process of new nurses. There is still a significant gap in the literature regarding nursing attitudes towards older adults with a DNR designation. This brings to question whether negative nursing beliefs about older adults might be influencing nursing care in relation to DNR status. Nonetheless, how nurses enact their practice with older adults with a DNR designation is not well understood.

2.5 Acute Care Nurses Attitudes towards Death and Caring for Dying Patients

Combined with aging, death is an unavoidable part of the life cycle, and health care providers such as physicians and nurses play an essential role in the care of dying patients in acute care (Dunn, Otten, & Stephen, 2005). With increased life expectancy and expanding health care technology nurses are becoming increasingly responsible for caring a larger population of dying patients in acute care (Dunn, Otten, & Stephen, 2005; Johansson & Lindahl, 2011). The care that nurses provide dying patients and their families may be influenced by their attitudes.
The literature regarding nursing attitudes towards death and dying needs to be examined as it will enhance our understanding of how older adults with DNR designated are cared for at the end of life situations.

A growing number of researchers have examined nursing attitudes towards death and care of dying patients in acute care. This research suggests that nursing attitudes are shaped by larger contextual features such as religious, philosophical, cultural and societal belief systems along with individual characteristics of the nurses (Braun, Gordon, & Uziely, 2010; Dunn, Otten, & Stephen, 2005; Gama, Barbosa, & Vieira, 2012; Lange, Thomm, & Kline, 2008; Mak, Chiang, & Chui, 2013; Matsui & Braun, 2010; Roman, Sorribes, & Ezquerro, 2001).

Nurse characteristics have been shown to influence attitudes. Older nurses and nurses with more years of nursing experience are more likely to report positive attitudes (Braun, Gordon, Uzeily, 2010; Gama, Barbosa, & Vierira, 2012; Lange, Thom, & Kline, 2008; Roman, Sorribes, & Ezquerro, 2001). The more experience nurses have with dying patients, the more positive attitudes they develop (Dunn, Otten, & Stephens, 2005). Lange, Thom and Kline (2008), used a convenience sample of 355 nurses in a comprehensive cancer center to assess feelings about death and caring for dying patients. They implemented two questionnaires, the Frommelt Attitude Toward Care of Dying (FatCod) and the Death Attitude Profile-Revised (DAP-R). Results revealed that nurses aged 50 years or greater scored higher on the FatCod, reflecting more positive attitudes towards caring for dying patients than their younger counterparts. Likewise, nurses with 11 or more years of experience viewed death as an escape from a painful existence and scored higher on the DAP escape subscale. Despite having a large sample size and utilizing two instruments with high validity and reliability, the setting of this
study in a cancer center limits generalizability. The authors proposed that older nurses have more life experience and possibly more education whether it is formal or informal regarding the care of the dying and thus develop more positive attitudes.

Similarly, Dunn and colleagues (2005) utilized a convenience sample of 38 nurses and employed both the FatCod and DAP-R with nurses practicing in oncology and medical/surgical units. Their findings also indicated that nurses with more years of experience viewed death as relief from a painful existence and that nurses who spent more time and had experience with dying patients were more likely to report positive attitudes. Despite the results, Dunn and colleagues still suggest that nurses can benefit from continuing education programs on the dying process in order to develop better care strategies and coping mechanisms regardless of age or years of experience.

In their descriptive correlational study, Gama and colleagues (2012) found that medical, oncology and hematology nurses had a higher fear of death and death avoidance than palliative care nurses. Their data sample consisted of 360 nurses from internal medicine, hematology, palliative and oncology departments in Lisbon, Portugal, and data were collected through DAP-R scale and the adult attachment scale. According to Gama and colleagues (2012) adult attachment refers to the tendency of a person to keep close contact with one or more figures seen as sources of security. The adult attachment scale is composed of 18 Likert type items that are scored from one to five and follow a range. They proposed that nursing background and experience leads to less anxiety towards death and more positive attitudes towards caring.
Attitudes of nurses regarding dying patients and care have shown to be influenced by religious background, personal beliefs and culture as well (Braun, Gordon, & Uziely, 2010; Gama, Barbosa, & Vierira, 2012). Findings from the Braun, Gordon, and Uziely (2010) study of Israeli oncology nurses attitudes towards death and dying patients, indicated that nurses hold positive attitudes. Further, attitudes towards caring were negatively correlated with death avoidance, fear of death, death approach and the approach acceptance to death. The approach acceptance to death is when individuals view death as a passage to a better afterlife (Braun, Gordon, & Uziely, 2010). Additionally, nurses that demonstrated lower levels of death avoidance were more likely to hold positive attitudes to care. The researchers proposed that the cultural background of the study may have influenced these results as, most nurses in sample were Jewish and the research instruments used primarily focused on interpretations of Christian beliefs. Philosophies related to acceptance of death and afterlife may not have the same meaning in all cultures (Braun, Gordon, & Uziely, 2010). In addition, the researchers suggest that having the personal awareness of personal attitudes towards death may help nurses caring for dying patients understand their own behavior when being faced with end of life processes. In this way, it is important to understand nursing care of older adults with DNR designations on medical/surgical units in acute care, further research is necessary to support the practice of acute care nurses with the older adult population.

Qualitative studies have highlighted the importance of showing compassion and sensitivity towards the needs of dying patients by nurses as well as how attitudes are constrained by their nursing work culture (Clarke & Ross, 2006; Costello, 2001; Mak, Chiang, & Chui, 2013). In their study, Clarke and Ross (2006) interviewed nurses, students and support workers
on general medical and palliative units regarding influences on nurses communication with older people at the end of life. In contrast to the palliative care nurses, the medical nurses in the study described time constraints and unit expectations as interfering with the care of the dying where physical needs and technical tasks were highly valued. Value and attitude conflicts in relation to care were also more evident on medical units. This may be explained by differences in patient centered care philosophies and patient care priorities (Clarke & Ross, 2006).

Mak and colleagues (2013) described the experiences and perceptions of nurses caring for dying patients and their families in acute medical settings. Interpretive description was used to explore these experiences of 15 nurses from three acute medical wards in Hong Kong. Their analysis revealed four major themes: lack of preparedness for patients’ death, reflecting on own nursing roles for dying patients, reflecting on the meaning of death and personal experiences of the death of their own family members, and coping with caring for dying patients. Their findings revealed that caring for dying patients in acute medical settings proved to be extremely straining on nurses. The sudden deterioration and rapid death of patients was highly distressing for nurses in acute medical wards. In addition, nurses identified barriers to providing quality nursing care for dying patients, such as heavy workload, fewer nursing staff, lack of time to care and the task orientated work culture. The nurses also discussed how medical dominance in Hong Kong undermined nursing care and attributed these factors to their inadequate nursing role in providing quality end of life care. Findings also showed that nurses’ experiences and perceptions regarding the care of dying patients were highly dependent on the specific patient situation, and whether or not nurses felt suboptimal care was provided. Although this study offered an examination of
experiences and perceptions of acute medical nurses caring for dying patients it did not offer insights as to whether nursing experience influenced these perceptions and experiences.

Despite, the move towards providing individualized care to dying patients, research indicates that nurses are still reluctant to openly communicate about death with their patients (Casey et al. 2011; Costello, 2001). Communication is trumped by ward culture, personal death and experiences attitudes, interpersonal power relations, beliefs about patient and nurse relationships and protective approaches (Casey et al. 2011; Costello, 2001; Mak, Chiang, & Chui, 2013; Schulman-Green et al., 2005). Black (2007) examined the communication regarding advance directives in relation to personal death attitudes and experiences of 135 health care professionals. These professionals included nurses, physicians and social workers who primarily worked with older adults in cardiology, pulmonary and intensive care areas from one hospital in New York State. Based on the bivariate analyses, the findings suggested that communication regarding advance directives differed based on death attitudes and experiences. For instance, a positive correlation was found between the initiation of advance directives and with acceptance of death, In other words, professionals holding optimistic views related to death are more likely to initiate conversations about advance directives with patients. In addition, findings also indicated a negative correlation between fear of death, death avoidance and escape acceptance. Escape acceptance of death attitudes exemplifies a view of death based on the bad aspects of life but not on the good virtues of living (Black, 2007). Also, health care professionals were more likely to initiate and disclose information regarding advance directives when they had personal experiences with terminal illness situations. Contrary to the previous studies, the findings of this study revealed that older health care professionals with experience working with older adults
reported an increased fear of death and death avoidance attitudes in comparisons to their younger counterparts. The results of this study imply that interactions with patients and health professionals may be influenced by personal attitudes and experiences about death and dying. Clearly, the management of dying patients requires the provision of high quality and sensitive nursing care including how information about death and dying is discussed amongst nurses as well as with patients and their families. Implications of Nursing Attitudes towards Caring for Dying Patients

As the numbers of hospitalized older adults have grown, the amount of terminally ill dying patients has increased in acute care (Mak, Chiang, & Chui, 2013; Thompson, McClement, & Daeninck, 2006). For this reason, nurses encounter multiple challenges in providing quality care to dying patients in the acute care context (Bloomer, Endacott, O’Connor, & Cross, 2013; Brereton et al., 2011; Casey et al., 2011; McCourt, Power, & Glackin, 2013; Thompson, McClement, & Daeninck, 2006). Implications of care relate to acute care nurses becoming more aware of their own attitudes, beliefs and care practices as well as enhancing their understanding the dying process (Dunn, Otten, & Stephens, 2005). Consequently, education is essential in gaining a global understanding of the perspectives of both nurses and patients about the dying process so that safe and competent care can be practiced (Dunn, Otten, & Stephens, 2005).

Findings from Formmelt (2003) clearly indicate that student attitudes towards caring for the terminally ill and their families changed and became overwhelmingly more positive through an education program. In this way, continuing education programs can help nurses to challenge their own fears, beliefs, attitudes and anxiety relating to death. In addition, this education can help nurses to identify barriers within the health care system, the institution and the unit which
prevents the creation of positive experiences for care providers and families. Increasing knowledge in this area will allow nurses to effectively collaborate with policy makers, managers and other interdisciplinary health care team members to help patients die peacefully and with dignity in the acute care context.

Since, death is an inevitable part of life; new nurses will surely encounter patient deaths working in the acute care. Education about death and caring for the dying needs to begin at the undergraduate level to form positive attitudes (Dunn, Otten, & Stephens, 2005). By working in acute care and learning from their past educational experiences, new nurses can develop effective coping strategies to reduce anxiety associated with caring for dying patients and their families. Additionally, it allows experienced nurses to reflect upon their own practice and belief systems about end of life care of DNR designated patients and to enhance quality care and communication surrounding death. It also provides nurses with leadership roles and role modeling opportunities so that they can critically analyze of how the care of dying patients is organized and constructed within the acute care.

2.5.1.1 **Summary of Attitudes towards Death and Caring for Dying Patients**

Upon examining the research, it is clear that the attitudes of nurses in acute care towards death are highly dependent on professional background, age, years of experience, personal experiences, philosophical and religious belief systems and practice environments. The findings of these studies strongly suggest the importance of educating nurses about the dying process as it influences attitudes, behavior, and ultimately nursing practice. Nurses in acute care are in a context that pulls them in all directions which makes their work caring for dying patients
extremely challenging. These nurses have to balance their own beliefs and attitudes while working in these types of environments. Nurses have to provide care that is respectful and sensitive to the needs of the patients and their families. Educating nurses about death and the dying process is a recurring theme throughout the studies, whether it is starting from the undergraduate level, from novice nurses to advanced practice nurses. Even though, nurses in general hold a positive attitude towards death and caring for those who are dying, the lack of open communication about death and death anxiety still remains.

The findings from these studies add to our knowledge about nursing attitudes towards death and dying and the experience of providing care to dying patients within the acute care context. However, how nurses’ attitudes influence their practice with DNR designated dying older adults in acute care is still not clearly understood. Further research is needed to understand the nursing practice with older adults who have DNR designations.

2.6 Chapter Summary

In this chapter, I have presented a review and synthesis of the current literature on acute care nurses attitudes towards older adults, attitudes towards death and dying as well at their knowledge of and attitudes towards DNR. A review of the literature identified qualitative, quantitative and mixed methods studies. Studies have been conducted in different countries and practice areas have been included in this review.

Registered nurses in acute care hold varying attitudes towards older adults. These attitudes have been shown to be significantly correlate with area of practice, age and professional educational. Acute care practice environments that tend to focus on routine tasks, efficiency and
high levels of technological skill promote negative attitudes and divert attention from patient centered care (Jacelon, 2002; Pursey & Luker, 1995). Nursing care is further complicated within this type of practice environment when nurses become responsible for caring for dying older adults.

As acute care nurses are increasingly becoming responsible for caring for aging older adults who are dying in acute care settings, the lack of knowledge and understanding of DNR orders of acute care nurses is apparent in the literature. DNR has become expanded and misapplied negatively influencing nursing and medical interventions (Jezewski, Scherer, Miller, & Battista, 1993; Thibault-Prevost, Jensen, & Hodgins, 2000). Although, there is a general vagueness in surrounding the term, nurses in acute care do support DNR orders, advance directives as well as living wills particularly when requested by the patient or family members. While physicians are primarily responsible for making the DNR decision and feel, acute care nurses voiced frustration in their lack of involvement in the DNR decision and feel their knowledge is disregarded (Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000).

Acquiring an understanding of nurses’ care experiences care for older adults with a DNR designation in the acute care setting is essential. Expanding this knowledge will assist the formation of educational programs for nurses at individual and organizational levels. It will also help dispel current underlying negative beliefs, stereotypes and attitudes towards older adults and end of life care while promoting better practice of acute care nurses.
2.7 Gaps in the Literature

Upon examining the existing literature, it is evident that the amount of qualitative research regarding nurses’ experiences caring for older adults with DNR designations is limited. Although, there is a considerable amount of quantitative survey research regarding attitudes towards older adults, death and dying as well as DNR, it is apparent that qualitative research regarding acute care nurses in particular medical/surgical nurses is lacking. As qualitative research aims to discover meaning and a holistic understanding of a particular phenomenon from the perspectives of those involved (Polit & Beck, 2012), I believe it is essential to further examine the experiences of acute care nurses caring for their older adult patient with a DNR status in a deeper manner. In addition, by further examining nursing experiences through a qualitative study design, a larger picture of the contextual and relational complexities of the nature of their experiences can be further appreciated.
CHAPTER 3: RESEARCH METHODS

3.1 Introduction

In this chapter, I describe the methods and methodology that will be used for the study. The purpose of my study is to extend understanding of nursing care of older adults with DNR designations on acute medical/surgical units in acute care. A qualitative method of inquiry was chosen for this research project because I was seeking to understand nursing care of older adults with DNR designations on acute medical/surgical units. I will begin by describing the theoretical perspective that was used to guide the study, followed by a description of the research design, an explanation of the population of interest, inclusion criteria, sampling strategy, recruitment methods, procedures and data collection. I will then explain the methods used for data analysis and ethical considerations. Finally, I will discuss the various strategies used to ensure rigor and quality in the research process.

3.2 Theoretical Perspective/Lens

Although biomedicine coupled with traditional bioethical theory, has made great advances in treating and comprehending countless medical problems, there are significant drawbacks, which necessitate a more contextual approach (Storch, Starzomski, & Rodney, 2013). Specifically, bioethical theory, as described by Gadow (1999), is characterized by the objective application of universal principles to determine the best moral action. Although the application of ethical principles can be useful in sifting through the ‘facts’ of the particular situation, moral deliberation in nursing may not be adequately dealt with by these ethical principles (MacDonald, 2007). Moral agency in nursing is enmeshed in the subjective experience of the interpersonal
relationships between nurses, patients and emotional vigilance to the individual’s unique experiences. Understanding nurses’ enactment of their moral agency therefore requires an examination of the contextual elements of the particular situation. In this way, attention is directed towards the unique experience of the individual (Gadow, 1999; MacDonald, 2007; Storch, Starzomski, & Rodney, 2013). Through examining the care experiences of medical/surgical nurses with DNR designated older adults, an analysis of the contextual elements of acute care environment occurs.

The specific nature of the relationship between nurses, patients, health care team and the socio-political climate of the health care system have been identified as key elements in influencing nursing practice (Doane & Varcoe, 2007; Storch, Starzomski, & Rodney, 2013). These elements promote the examination of a theory in nursing ethics that conceptualizes the nature of the relational context in nursing. The postmodern philosophy of relational ethics (Bergum, 2004) presents an analysis and understanding of what influences nurse’s moral agency. In this way, relational ethics directs one to examine the relational space, particularly the nature and quality of nursing relationships and how they influence nursing practice (Bergum, 2004; Doane & Varcoe, 2007; MacDonald, 2007). The philosophy underpinning relational ethics places an emphasis on the community of relationships and interactions that influence the particular situation. Bergum (2004) identifies four themes that describe relational ethics within nursing: environment, embodiment, mutual respect and engagement.

Environment explores pivotal characteristics of the health care system in which nurse’s practice and how nursing relationships are influenced by this larger macro system. Embodiment allows the recognition “that scientific knowledge and human compassion are given equal
weight...emotion and feelings are as important to human life as physical signs and symptoms” (Bergum, 2004, pg. 492). Mutual respect is described as the embracing of values, perspectives and ideas of others to promote and develop new understandings rather than discriminating against these values and ideas. The theme of engagement stresses the promotion of an emotional connection between nurses and patients. This type of engagement allows nurses to develop a holistic and meaningful understanding of the patient’s experience.

From Bergum’s writing we can see that relational ethics asks for the engagement and reflection on the relationships in the moment. Other theorists emphasize that relational ethics asks us to also consider the layers of relationships and power dynamics in which all people (health care providers, patients and their families) are embedded (Doane & Varcoe, 2007; Storch, Starzomski, & Rodney, 2013). This inquiry lens describes how care of patients requires more than individual nurses taking caring attitudes and practice approaches by drawing attention to how personal and contextual forces influence both the nurses’ and patients’ capacities (Doane & Varcoe, 2007). Thus, this fits well with the purpose of my study, which is how nursing care is enacted with DNR designated older adults in an acute setting. Relational ethics emphasizes how people are contextual entities who reside in relation nested, within social, cultural, political and historical processes (Doane & Varcoe, 2007). Thus, individual experiences, interpretations, as well as actions are due to multiple relational interactions and processes and individuals are both affected by and affect other individual’s responses, experiences and contexts (Doane & Varcoe, 2007; MacDonald, 2006). This inquiry lens calls for an in-depth examination of experiences, goals and issues influencing action within a particular moment in practice as well as reflection on intentional responsive action (Bergum, 2004; Doane & Varcoe, 2007).
By providing the understanding, nurses caring for DNR designated older adults are embedded in a relational context; relational ethics provides a meaningful perspective from which to study the nursing care of older adults with DNR designations in acute care. Relational ethics provides nurses the opportunity to enact the “health care environment, embodiment, mutual respect and engagement through the daily care of people who experience illnesses, trauma and even death” (Bergum, 2004, pg. 502). Relational ethics addresses the larger contextual influences and constraints that shape nursing practice within complex socio-political climates of the health care system. Therefore, relational ethics provides an important analytic lens from which to study the complex layered context of DNR orders as well as the systematic structures which influence nursing care and practice of older adults.

3.3 Study Design

Qualitative approaches strive to discover meaning and to arrive at understandings of a particular phenomenon from the perspectives of those involved (Polit & Beck, 2012). Qualitative research accomplishes this by describing social experiences, including how these experiences are created and what meaning the particular phenomenon has for individuals involved (Holloway & Wheeler, 2010). Qualitative approaches aim to explore the behavior, feelings and experiences of people (Holloway & Wheeler, 2010). Many qualitative approaches can be used to accomplish understanding; therefore, it is essential to examine the research question to determine which method to employ (Polit & Beck, 2012). Because I was seeking to understand the nursing care of older adults with DNR designations on medical/surgical units in acute care within the qualitative research paradigm, Interpretive Description (ID) was used as the guiding methodology to inform this study.
3.3.1 Interpretive Description (ID) Methodology

Interpretive description was initially explained by Thorne and colleagues in 1997 (Thorne, 2008). Interpretive description is philosophically inspired by phenomenology, grounded theory and ethnography and recognizes the socially constructed and contextual nature of human experiences (Hunt 2011; Thorne, 2008). Interpretive description is founded in nursing and adheres to the systematic logic of the nursing discipline (Thorne, 2008). This approach is inductive in nature whereby the researcher searches for an understanding of a clinical phenomenon such as the care experiences of nurses. The purpose is to reach a coherent conceptual description that draws from thematic patterns describing the phenomenon (Thorne, 2008). Interpretive description appreciates the notion that individual experiences are formulated through complex interactions where common patterns illustrate nursing knowledge.

Interpretive description presumes that nurse researchers look beyond description but aim to explore meanings and explanations that have practical applications (Thorne, 2008). The basis of interpretive description is the smaller qualitative investigations of clinical phenomenon based on informed questioning, using techniques of reflective, critical examination, which ultimately guide and inform the nursing discipline (Thorne, 2008). Through analytic interpretation the clinical phenomenon is made visible.

Based on the features of interpretive description as a methodology, it was an appropriate fit for my inquiry as I am interested in understanding nursing care of older adults with a DNR status in acute care. Furthermore, as interpretive description aims to examine questions of relevance from the nursing practice standpoint, it can comprehensively capture the nurse’s care
experiences, both examining thematic patterns and individual variations. This allowed me to move beyond descriptions of the nurse’s care experiences but also engage in interpretation from their perspectives. Finally, this methodology ensured that the study adhered to the principles of qualitative inquiry for nursing science at the same time permitted an exploratory and discovery approach.

3.4 Sampling Plan

3.4.1 Setting and Sample

For the purposes of my study, the target population consisted of Registered Nurses who cared for older adults on acute adult medical or acute adult surgical units within a 300 plus bed community hospital in British Columbia.

Acute medical/surgical nurses provide care to adults with acute, critical and chronic conditions. These nurses practice in settings where patients require specialized care such as complex and continuous monitoring, intricate or invasive therapies. For the purposes of my study, the population of interest was medical/surgical nurses who practiced on medical or surgical units. This population represented the most knowledgeable to best answer the research question. I decided to use purposive sampling, to only include nurses who currently worked on acute medical or surgical units. I recruited eight nurses from this setting using purposive sampling.
3.4.2 Inclusion and Exclusion Criteria

The inclusion criteria were: 1) working on a medical or surgical unit for more than 6 months and 2) working greater than or equal to a 0.5 full time equivalent (FTE) at the study site. It was assumed that medical/surgical nurses who participated would have different levels of experience and expertise in their practice which would contribute to the richness of the discussion. Therefore, a general requirement was to have experience working and caring for DNR designated older adults as well as willingness to participate in the study as indicated by informed written consent.

3.4.3 Sampling Strategy

Gaining a rich understanding of a topic is the intention of most qualitative studies. Therefore, when selecting a sampling strategy, generalizability is not a concern (Polit & Beck, 2012). Participants are chosen through a number of strategies based on their first-hand experience with the topic being studied. One of these strategies is purposive sampling where researchers utilize their judgment to select participants who they believe will best allow for the provision of rich information for the study (Holloway & Wheeler, 2010; Polit & Beck, 2012).

The sample sizes in qualitative research are fairly flexible, emerge as the study progresses, are informed by analysis, and are directed by the developing knowledge (MacDougall & Fudge, 2001). For the purposes of this study, the sample size was relatively small of eight participants as the ID methodology approach emphasizes an in depth exploration of the subjective experience which can only occur through engaging in a small number of individuals who are experientially familiar with the phenomenon of interest (Thorne, Reimer
Kirkham, & O’Flynn-Magee, 2004). In addition, a smaller sample size allows for a more refined capturing of the meanings that participants ascribe to their experiences (Holloway, & Wheeler, 2010; Polit & Beck, 2012). The main indicator for sample size was at the point at which redundancy or data saturation will be reached. Data saturation was determined when a sufficient amount of information with recurrent themes was reached or until little new information is obtained.

3.4.4 Recruitment Methods

According to MacDougall and Fudge (2001), recruitment can be challenging especially in cases where there is a sensitive practice issue. Other issues that can pose challenges in recruitment relate to when gatekeepers withhold access or it does not occur on the grounds of an existing relationship or affiliation (MacDougall & Fudge, 2001; Polit & Beck, 2012). A number of recruitment strategies were used to overcome some of these challenges. These included contacting managers and educators of acute medical and surgical units within the hospital to provide information about the study and to gain access to the target sample. Once approval was obtained from the managers and Health Authority Research Ethics Board, informational posters inviting medical/surgical nurses were distributed (Appendix C).

In addition to posters on the units, I wanted to distribute information to medical/surgical nurses through presentations at professional practice meetings on their units. Presentations at these meetings would have included background of the study, the purpose of the research and what would be required from those who participate. Copies of the participant information letter
(Appendix B) and consent form (Appendix A) were circulated at these meetings and copies. I also left copies on site with the unit managers and educators.

I encountered some challenges to this recruitment strategy. The managers and clinical nurse educators had informed me that the hospital site was undergoing major staffing changes, bed re-structuring and new policy implementation difficulties therefore I would not be able to take up time during professional practice meetings for my study. The surgical manager and educator had notified me that the surgical units would be undergoing major modifications and projected low surgical nurse participation. I had difficulty recruiting surgical nurses for my study; consequently, I had only one participant who had experience working on both surgical and medical units. I had discussed my difficulties with my thesis committee supervisor and the medical nurse educator. The medical unit nurse educator was able to assist me in recruitment in that she reminded nurses about my study during education sessions and encouraged nurses to participate especially those who fulfilled the inclusion criteria.

Over the course of three months, I was contacted by eight nurses via telephone who wished to participate. I set an interview date at a time and location that was convenient for them.

3.5 Procedures and Data Collection

Multiple data collection techniques were used to understand the experiences of medical/surgical nurses caring for older adults in relation to DNR designations. These data collection techniques included, semi-structured interviewing of individual participants, demographic participant information and reflective journaling/memoing. I was responsible for data collection; therefore no other investigators required training.
3.5.1 Semi-Structured Interview

Data were obtained through semi-structured interviews. In interviewing each participant semi-structured open ended questions were asked to encourage participants to share their experiences in caring for their DNR designated older adult patients. Nurses were encouraged to draw upon examples from their clinical contexts. I used the questions only as a guide. I asked other questions to obtain further clarification or to stimulate and focus discussions, as needed. (Appendix E) The questions in my interview guide fluctuated from general to more specific and included general questions such as “what does DNR mean?” and more specific questions such as “does a DNR designation influence the way nurses provide care for older adults?” See Appendix A for question list.

As the setting of the interviews is seen as a vital part of promoting an atmosphere where participants feel comfortable enough to express their narratives, thoughts and feelings (Holloway & Wheeler, 2010; Polit & Beck, 2012), participant input was sought about the location of the interview. The interviews took place at a time and location chosen by the participants, outside of their work hours. The interviews took place at coffee shops, participant’s homes and library rooms. Each interview was approximately an hour in length. Interviews were audio-taped through a digital recording device and subsequently transcribed verbatim by a transcriptionist. I provided participants with a twenty five dollar honorarium for their time and participation in the study. I had originally planned to conduct interviews with 6 to 10 interviews. I met my goal and conducted 8 interviews. Each participant was interviewed once.
3.5.2 Demographic Information

After written consent for subject participation was received, basic demographic data was collected at the beginning of each interview. Specifically, information collected included age, sex, and gender, and ethnicity, highest level of education and length of experience as both a registered nurse and in acute care. The demographic questionnaire was formulated in consultation with my committee. The information from the questionnaire provided the context of describing the sample. The questionnaire took about three minutes to complete at the outset of the study (Appendix D).

3.5.3 Reflective Journaling

In addition, reflective journaling was utilized to explain my personal views and insights as well how it impacted the research process. This allowed me to reflect upon my own positioning as a medical nurse. By devoting time and energy into analyzing personal presuppositions, problems and decisions, a commitment to reflexivity was demonstrated (Polit & Beck, 2012). In this way, engaging and documenting these personal constructions (bracketing) and their influence on the inquiry process enabled me to enhance the transparency and creditability of my research.

3.6 Data Analysis

The objectives of qualitative data analysis are to discover variation, portray various elements in meaning and to examine complexity (Rubin & Rubin, 2011). In this way, the goals of analysis are to reveal complexities in human interactions and to make these complexities
understandable to others through the words of the participants (Rubin & Rubin, 2011). Although there are various methods of qualitative data analysis, for the purposes of this study and in keeping in line with the interpretive description methodological approach, constant comparative analysis was used to analyze the data.

Interpretative description is dependent on the constant comparative method of analysis to acquire a holistic understanding of a human phenomenon in relation to the context in which it is experienced (Thorne, 2008). Constant comparative methods are rooted in the sociological theory of symbolic interactionism and involve comparing differences and similarities of one piece of data to another in order to develop conceptualizations and possible connections (Thorne, 2008).

In this study, where my purpose was to generate understanding of nursing care of older adults with a DNR status, this process involved the use of inductive analytic approaches. The analytic process was illustrated by a concurrent and responsive relationship between the analysis and data collection (Thorne, Reimer-Kirkham, & O’Flynn-Magee, 2004). According to Thorne et al. (2004), the objective of interpretive description is the formulation of a large conceptual description which examines commonalities believed to characterize the phenomenon but also accounts for the individual variations within them.

The process of data analysis began with the completion of the first interview. Data from each interview was analyzed as soon as possible following the interviews, by examining the transcripts. The first step in the analysis included the verbatim transcription of each interview, which included both words and selected non-verbal cues (Holloway & Wheeler, 2010). The services of a transcriptionist were used due to time constraints. Transcription of the interview
occurred immediately and I was able to read a completed transcript within 2 days of the interview. While awaiting the transcription, I engaged in reflective journaling and kept track of relevant thoughts and possible analysis material. The transcription was reread several times for accuracy and further immersion in the data (Holloway & Wheeler, 2010). In order to organize and order the data, all transcripts had details of time, location and comments attached (Holloway & Wheeler, 2010). The in-depth reading of the transcripts prevented the overlooking of significant issues and allowed preparation for subsequent interviews.

Analysis of the transcripts was initiated with the transcription of each interview so that insights developed during early interviews were integrated in the ongoing data collection. This allowed for a responsive interaction between the data analysis and data (Thorne, Reimer-Kirkham, & O’Flynn-Magee, 2004). The next step in the analysis included recognizing concepts, themes and events in the interviews (Rubin & Rubin, 2011). Subsequently, the process of coding began. According to Thorne, et al. (2004), “analysts are to avoid excessively detailed coding” (pg. 14) which can prevent the researcher to see patterns, differences and reasoning between pieces of data. Asking questions such as “what is the story telling me, what is happening here”, allowed me to remain true to the contextual nature of the data and engage intellectual processes, and helped reduce my own personal influences in relation to experiences, biases and disciplinary orientation.

Codes were generated from the raw data. Open coding was used to label specific pieces of the data, such as “nurse experiences with DNR”, “nursing stress”, “nursing practice/care of DNR patients”. There were approximately 18 codes generated. Once open coding was completed, codes with similar meanings were grouped and sorted into a table format. This table
was reviewed and revised with consultation of my supervisor. The codes were recorded on the hard copy transcripts next to each section/paragraph/sentence. The codes and their definitions were also documented in a separate file to ensure consistency and to remain alert to ideas as they appeared and were added to the coding structure. Once no further codes could be generated or data saturation occurred, codes were grouped into categories. Relationships between categories were examined by diagramming associative links among the categories. Categories were organized around the research question to which they pertained. This was an intricate process involving reading and rereading the transcripts to produce more abstract and refined ideas about the domains of interest in the participant experiences (Holloway & Wheeler, 2010). Computer files were created to organize categories and themes that spoke to the research questions and to make this process less cumbersome. This also provided a clear trail of my decision making process regarding the coding and how these codes were reached.

Next, the categories were reassembled to reveal an analytic scheme, which was further conceptualized into themes. These themes provided an interpretive description of the experiences of medical/surgical nurses caring for older adults with DNR designations. Themes were generated in different ways. For example, some themes related to explicit terms asked in the questions, other themes to the coding list, and a few themes were also revealed by exploring the tensions revealed by the interviewees (Rubin & Rubin, 2011). In addition, I compared the interviews; looked for parallels as well as examined the differences between them (Rubin & Rubin). The clustering of the data into subthemes and themes occurred collaboratively with my thesis supervisor.
3.7 Ethical Considerations

This study was conducted following Tri-Council Ethical Guidelines (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2012).

3.7.1 Protection of Human Subjects

Approval for this study was obtained from the University of British Columbia (UBC) Behavioural Research Ethics Review Board (BREB) and the Health Authority Research Ethics Board (HA BREB). Approval was obtained from directors and managers of the acute medical/surgical units for participation in the study after obtaining consent from UBC BREB. Information letters were sent to the managers on the study as well as copies of the approval certificates from the Research Ethics Board.

When potential participants contacted me, they were screened to ensure they met the study requirements via telephone. If they were still interested in participating they provided me with information so that I could contact them when I was arranging a time for the interview. Each participant had several days to a few weeks from the time they expressed interest in participating in the study to the interview to decide whether to participate. This time frame was never less than twenty-four hours required by both UBC BREB and HA REB. As practicing registered nurses, all potential participants were competent to give full informed consent for their participation in the study.
Prior to conducting the interviews, participants were informed that they did not have to take part in the study and could refuse to answer any questions and stop the interview at any time both verbally and in the informed consent. I reviewed the purpose of the study, the consent form, the voluntary nature of their participation in the study and issues with confidentiality. The interviews were conducted at a location of choice of the participant. In addition to written consent, verbal consent was required prior to conducting the first interview. This process incorporated consent for audio taping, transcribing the interviews and for reporting the descriptions.

Data collected during the interviews were managed in keeping with ethical principles. Interviews were transcribed verbatim following the interviews. Anonymity of the participants was protected, institutional names and identifying information was removed during the transcription. Participants were coded as Participant 1 (P1), Participant 2 (P2) etc., during the collection and analysis of the data. Interview tapes, identifying data and transcription were placed in a locked room with no public access. I stored all computer files on password protected hard drives and these passwords were protected and encrypted. Data will be stored for up to five years per UBC BREB guidelines and destroyed. Even though I plan to publish my research identifying information will not be used in the publications.

Despite the sensitive nature of the topic, minimal subject risk was anticipated (possibly emotional distress in recounting negative experiences). In this way, participants were informed that if they needed to they could be referred to an Employee Support Service, which is at no cost to the employee. I informed participants that they would not directly benefit from participating in the study.
3.8 Rigor and Quality

In qualitative research, investigators need to look beyond the “truth value” of their study but also need to exhibit the creditability and quality in their research (Holloway & Wheeler, 2010). Although, there is no single concept of validity in qualitative research, it must be methodologically rigorous. The research process needs to be clearly and coherently demonstrated (Cohen & Crabtree, 2008; Holloway & Wheeler, 2010).

I utilized several strategies throughout the data collection and analysis process to enhance the rigor and quality of my study. Lincoln and Guba’s (1985) quality framework was used for my study. Lincoln and Guba’s framework includes four criteria for developing the “trustworthiness” or rigor of a qualitative study. These four criteria are: credibility, dependability, confirmability and transferability of findings (Holloway & Wheeler, 2010; Lincoln & Guba, 1985; Polit & Beck, 2012).

Creditability is viewed as a paramount goal within this framework and refers to confidence in the truth of the data as well as interpretations made from the data (Polit & Beck, 2012). I undertook a number of measures to meet this goal. Member checking was undertaken throughout the research process. This measure included, summarizing, paraphrasing and probing the participant’s words during the interviews to ensure understanding of the participant’s meanings (Holloway & Wheeler, 2010). This allowed engagement in the field through context description, which allowed me to understand the fit amongst experiences between the respondents and my representation of them which contributed to data triangulation (Bradbury-Jones, 2007; Cohen & Crabtree, 2008; Polit & Beck, 2012). The reflective journaling and
verbatim transcription assured the accuracy of the participant’s experiences. Further, I reviewed the audio recordings multiple times to avoid errors in transcription. In addition, peer review occurred throughout the analysis process in regards to coding and theme identification through meetings with my supervisor (Bradbury-Jones, 2007; Holloway & Wheeler, 2010). Negative or disconfirming cases were included at the end of the data collection process which helped challenge my interpretations and suggested rival explanations thus enhanced the credibility of the findings.

The second criterion of dependability refers to the ability of the readers to evaluate the adequacy of the analysis by tracking the decision-making process of the researcher (Holloway & Wheeler, 2010). In order to achieve this, I kept a clear description of the methods of data collection and analysis throughout the study. The audit trail included an explicit record of the decisions made before and during the research process and a description of the research process (Holloway & Wheeler, 2010). I kept all records including interview transcripts, process notes, and theoretical notes and working hypotheses. All documents relating the context, methodology, analysis and personal responses were kept (Holloway & Wheeler, 2010).

The criterion of confirmability refers to objectivity. Confirmability entails that the findings are representative and reflective of the conditions of the inquiry and participant perceptions rather than the perspectives of the researcher (Polit & Beck, 2012). I used direct quotations from the participants in the descriptions of the themes so that the reader can judge whether the findings are representative of the participant’s perspectives and experiences. In addition, I maintained a reflective journal in which I was able to engage in reflexivity. Reflective journaling allowed me to critically reflect on my own preconceptions and monitor reactions and
emotions to participants’ narratives (Holloway & Wheeler, 2010). For example, I often asked myself, “what are my feelings about this situation?” or “why do I feel upset hearing about this?” This process also allowed me to reflect upon my own experiences and biases as a medical nurse with experiences caring for DNR designated older adults. The final criterion proposed by Lincoln and Guba (1985) is transferability or the extent that findings are applicable to other settings or group. I attended to transferability through a detailed description of the participant practice setting and included a demographic questionnaire of sample of medical/surgical nurses who participated in the study. According to Thorne, Reimer-Kirkham, & O’Flynn-Magee (2004), the best interpretive descriptions will pass the “thoughtful clinician test, in which those who have expert knowledge of the phenomenon... find that the claims are plausible and confirmatory” (pg. 17) as they highlight new understandings and possible relationships.

3.9 Limitations of Study Design

There are limitations incurred with the interpretive description methodology. A considerable issue is that interpretive description is a relatively new methodology with a modest amount of examples of research (Hunt, 2009). In addition, limitations also relate to interpretive description’s close resemblance to aspects of other methodologies such as grounded theory. Hunt (2009) describes a potential danger with interpretive description in that researchers might have difficulty in sufficiently interpreting and abstracting the data, which ultimately limits the findings especially in regards to its practice application.

There are possible limitations with interviewing as the primary form of data collection. The veracity of these interviews may be questionable as the nursing care experiences were
retrospective in nature and relied heavily on the participants’ memories (Holloway & Wheeler, 2010; Riley & Hawe, 2005). For example, many participants stated that they could not recall detailed scenarios relating to the research questions. In addition, their responses might have been based on what they believed would be their experience rather than their actual experience.

Since constant comparative analysis required an in-depth understanding, recognition and engagement with the participant’s experiences, the issue of blurring of interpretative boundaries between the researcher and the participant can transpire (Riley & Hawe, 2005). Thorne, Reimer-Kirkham, and O’Flynn-Magee (2004) further explain this by suggesting that the researcher can play too strong of an interpretative role without connecting back to the raw data and researchers can play too weak of an interpretative role through a lack of analytical attention to intersecting contexts. In addition, ID encourages the researcher to reflect upon what the data encompasses as well as alternative viewpoints which makes systematic coding of the data difficult therefore it confirms the importance of guiding analytic principles (Hunt, 2009). Introspective reflexivity is essential in this process.

There are issues with the sampling method as they can have an effect on the findings. The small sample size with purposive sampling may have limited the richness of the data generated and may be inappropriate to generalize the data beyond the participants of the study (Polit & Beck, 2012). Further, I had difficulty recruiting surgical nurses for the study, which may have limited the breadth and depth of data collected. Surgical nurses have important perspectives and unique experiences caring for DNR designated older adults that are not represented in the findings. In addition to this, only one hospital site in a specific health authority was used for the research setting possibly adding to this limitation.
3.10 Dissemination of Findings

I plan to disseminate the findings of my research study by publishing this project in a peer-reviewed journal to widely communicate the results of this study. I also plan to communicate the results of my study to those involved in the research process. I will offer to present the findings of my study to staff as well as to the management of the units where recruitment took place.

3.11 Chapter Summary

A qualitative research design was used to answer the questions:

1. How do nurses define DNR?
2. What do nurses view as the role of the Registered Nurse (RN) in relation to DNR status?
3. How does the context of acute care influence nursing care of older adults with DNR designations in medical/surgical units?
4. What do nurses see as barriers and facilitators to their ethical practice related to DNR orders?
5. Based, on research questions #1 to 4, what are the implications for nursing practice with older adults who have a DNR designation?

Relational ethics was the theoretical lens guiding this study. Interpretive Description was the research methodology chosen to inform this study. A purposive sampling method was used to select the medical/surgical nurses who provided in depth information on this research question. Medical/surgical nurses were recruited within an urban community hospital from the Lower
Mainland in British Columbia. Data were collected primarily through semi-structured interviews. The data obtained from the semi-structured interviews was analyzed using the constant comparative analysis. Various measures were undertaken throughout the research process to enhance the rigor of the study. In addition, careful attention was paid to the various ethical aspects of the study.
CHAPTER 4: FINDINGS

4.1 Introduction

In this chapter, I present the findings from my study of nursing care of older adults with a DNR designation on medical/surgical units in acute care. I begin by providing a description of the sample participating in the study. I then describe the themes that were generated using the interpretive descriptive approach. Thorne (2004) suggests that the emergent patterns and themes should be ordered so that we "might make sense of the most important ideas to be conveyed and access their meaning in a new manner" (p.15). Drawing upon these principles, important ideas inherent to the study are presented as themes.

4.2 Description of the Sample

The sample consisted of eight Registered Nurses who cared for older adults on an acute medical unit within an urban community hospital in British Columbia. One nurse had experience working on both acute medical and surgical units at the setting. There were seven female participants and one male participant in the study. The average age of the eight participants was 32.4 years, ranging from 23 to 53 years. Three of the nurses identified their ethnicity as Caucasian, one as Indian, one as Hispanic, one as Filipino, and two as Asian (Korean and Chinese). The length of nursing experience ranged from eight months to 20 years with a mean of six years. The highest level of education also varied among the participants. Of the eight participants, four had obtained a diploma as the highest level of education; four had an undergraduate degree and one held a post graduate specialty certification.
4.3 Themes

Using data from the nurses’ descriptions of their experiences caring for older adults with DNR designations in acute settings, five themes were developed. These were: (1) nurse’s conceptualization of DNR, (2) nurse’s role in relation to DNR, (3) context of acute care in relation to practice and care, (4) barriers to care and (5) facilitating factors in providing good care to older adults with DNR designations. Each theme is composed of sub-themes, which further developed the theme. In the next section, I describe each theme and subtheme using direct quotations from the participant interviews as necessary. Participants have been labeled as Participant 1, Participant 2 etc. and all identifying information has been removed to maintain anonymity of the participants.

4.3.1 Conceptualizing DNR

The first theme that I developed was how nurses define the term DNR. The nurses used different words to define what DNR was, and provided specific examples of events that highlighted the meaning of DNR. Some of these examples were related to practice, while others were related to outcomes. The subtheme of nurses’ knowledge and understanding of DNR captures the various ways that nurses classified DNR and acknowledged both the ambiguity and certainty of the term. Nurses conceptualized DNR was influenced by their area of practice and the patient population. They were dealing with sick older adults at the end the end of life.

Nurses’ conceptualizations of DNR were also influenced by the study site’s new Medical Orders for Scope of Treatment (MOST) / Advance Care Planning form. This new standardized hospital policy represented a second subtheme. The nurses described how their understanding
and knowledge of DNR was affected, and in some cases changed and further defined by this important hospital policy. The conceptualization and understanding of DNR appeared to be embedded in individual experiences, and relational interactions. Nursing emotions/beliefs is the final subtheme under definition of DNR. Nurses describe their emotions and beliefs of the complex layered context of DNR orders and how it influenced their understanding and knowledge of DNR orders.

4.3.1.1 Nurses' Understanding and Knowledge of DNR

Acute care Registered Nurses provided a number of descriptions of how they understood and defined the term DNR. All participants were able to describe the literal definition of the term and what it encompassed. One participant clearly explained what DNR means and the health care professional’s responsibility caring for a patient during a cardiac arrest,

(P3): DNR...the meaning we learn for work is ‘do not resuscitate’ meaning if a person expires or stops breathing, their heart stops pumping, the health care professionals will not attempt to do artificial breathing things, or artificial, uhh, compressions to resuscitate the person from death. Yeah.

When asked to describe what a DNR designation meant to them, nurses provided broad terms such as “no cpr (no cardiopulmonary resuscitation)”, “do not send to critical care”, and “die naturally” Some of the ways in which DNR was described alluded to allowing people to die naturally and comfortably without aggressive treatment especially if the patient was an older adult. One nurse explained,

(P2): When I practice, and then my patients have DNR status, then in case they go into cardiac arrest or respiratory arrest, then we will not intervene with any medical means, but just let the course take its natural path.
Participants’ knowledge about DNR was also highly linked to their patient’s current diagnosis, prognosis and age. Participants often spoke about how DNR status was necessary and warranted for patients who were acutely ill and in medically futile situations. Nurses emphasized that DNR had multiple complex components that included still providing medically necessary care. The nurses spoke of their past experiences with patients who had a DNR status to explain and further define their knowledge.

(P6): That somebody can be a DNR but we can still do invasive procedures, like intubate, and put to critical care, meaning they’ll get central lines, they’ll get pegged to, like that kind of stuff.

Their knowledge of the various care modalities of DNR and categories and its incorporation into practice was highly linked to the hospital policies and unit guidelines.

In addition, the nurses described their knowledge of DNR decision-making process. They stressed the importance of the complexity and sensitivity of the decision which mostly involved the physician, the family and the patient. The nurses further pointed out the compassion and respect that needed to be shown toward this decision.

4.3.1.2 *Hospital Policy and Directives*

All participants were aware of the new standard Medical Orders for Scope of Treatment (MOST) / Advance Care Planning policy in the hospital. The nurses recognized the need to clarify the interpretation of DNR in clinical practice. Nurses were aware that this policy was designed to better articulate exactly what DNR orders mean for particular patients and associated treatment modalities. One nurse stated,
We have DNR M1, M2, M3 that, umm, clarifies if patient, uh, can transfer to ICU, or if patient could be a full medical plus on monitors, on cardiac monitor. And, on third side will be just medical treatment, no transfer to ICU, no cardiac monitors, no tele-monitors, ummm, just make them comfortable, symptomatic comfortable. But we’re still doing whole bunch of antibiotics, all the, you know, bronchodilators, and the whole bunch of medicines; IV and PU. And patients will have NG tubes, feeding is going, and so, just to make them comfortable because different families will make different decisions. So even their DNR I know, it helps with differentiating if patient can be transferred, or if stay on a medical unit, or patient could be on a monitors, so just to make their condition comfortable I think.

The nurses acknowledged the complexities of the DNR decision making process in particular the stress that it involves for family members, as sometimes the DNR decision is made in a constricted amount of time usually when the patient is deteriorating. One nurse explained that the new standardized advance care planning policy “provides more choices for the patients and family.” In addition the nurses found that it helped the patient’s exercise control over their end of life care and it that provided a clear outline for family members or next of kin to make decisions on behalf of the patient.

Probably, I would always clarify anyways because it is such a personal thing and you’re having a lot of interaction with family, and sometimes family doesn’t really know what a DNR would mean, and sometimes they...umm...when the patient actually dies and they’re there, I’ve had it happen where they’ve been upset that you haven’t done CPR. They’ve said, “aren’t you...going to do something?” When in actual fact, I’ve assumed that it’s been explained to them by the doctor. So I guess what it is now, there’s no assumption, it takes away that assumption.

While the nurses emphasized how this policy promoted patient autonomy they found the different DNR levels to be extremely overwhelming for family members. As one nurse explained,

But it’s a lot for them to take in, like, especially now that we’ve changed our DNR, we’ve got different levels of DNR and CPR so, it gets a little confusing to
the families right? They haven’t seen this thing before, what all this means, so, I mean, the doctors do try their best, but yeah, it can get confusing for the families as well.

The nurses indicated that in situations of rapid patient deterioration the lack of time for education for patients and families added to the confusion of allocating the appropriate DNR level to the patient.

The nurses had conflicting opinions about the new hospital policy and how it influenced their care practice. The nurses often spoke about how DNR and Full Code statuses had been perceived and understood prior to the policy. Some nurses viewed the new policy positively, as they felt that it provided clarification to their practice when they cared for a rapidly deteriorating patient,

(P7): Because, like, now patients, if they are DNR C1, then patient can still go, you can still send them to ICU. And then if it’s a patient is DNR M3, I think that’s the one with the patient like, basically the patient’s more in a comfort care situ...you have a clear picture of what the patient’s going to be like, like what kind of interventions you’re going to provide on the doctor too can have a better uh, picture of how, how, how they kind of intervene with the patient’s condition

These levels of DNR helped reassure some newer nurses, as it helped outline their practice and necessary interventions that the patient required. The nurses explained that these levels helped organize their care and structured their priorities. As one nurse explained,

(P5): Quite helpful, yes. So at least you can just, you know, first thing in the morning you check your patient, or, you know, whenever you start your shift, you look at your patient DNR, now we don’t say, we used to say patient is DNR, we don’t say DNR, we say DNR M1, or we say DNR M2, or M3. So that clarifies what the patients are actually requiring

Other nurses described that the different levels in DNR interventions were conflicting, that the basic essence of choosing not to resuscitate was complicated by other factors such as patients or
families choosing intubation and transferring patients to ICU. They felt that these invasive interventions further removed the patient from his/her original end of life care wishes and sometimes promote unnecessary subjection to unwanted highly intensive medical interventions.

(P6): I find it conflicting because there has been a few cases where...where it’s just like they go from...they come in saying I want to die naturally if a cardiac event or whatever happens, and also that kind of gets flipped and switched and changed, and in the chaos they get, like, thrown into ICU, get tubes shoved down their throat because like, there’s no clarification, there’s no like, yes or no, there’s no black and white, it’s a grey, very grey area, it’s...kind of confusing.

Another nurse commented,

(P2): I don’t know. I...I...think I have a very conflicting view of it because, first of all, when it first came out, umm, it was so confusing, because there’s so many, I think there are six different levels for us to get adjusted to. And this, it’s like, oh, every time, something goes like, “what is it? DNR? DNR what?” So, umm, and, I was at, I was questioning why is that necessary? Like why is...I’m sure its based on some evidence based research, but umm, DNR where it says, “intubation is okay versus intubation as well as resuscitation is okay” what’s the difference? And what makes patients choose one over the other, you know what I mean? Yeah.

The nurses discussed how these various intervention levels forced them to question the practical and ethical implications for their patients. A few nurses wondered whether these intervention levels prevented people from dying peacefully, or helped removed the guilt that family members associated with DNR. One nurse explained,

(P6): So it’s like, like...he’s a DNR, but what is like, do...do people ever take that seriously. Like, I understand it was a scary event for the wife to see because her husband’s not dying. But the fact that they can take a...what was used to be black and white and switch it to a grey area and be like, oh, well we can do all these interventions, and try to keep him alive even though that’s not what he wanted. And he was, I think he was like, what, 83?
Although, these various levels were identified to clarify the care interventions in relation to code status, the nurses questioned whether it was taking DNR away from its original intention. Regardless, the nurses voiced that the policy clarified the literal definition of DNR.

4.3.1.3 Nursing Beliefs

Participant’s unanimously believed that DNR orders were written when quality of life would be poor or when resuscitation efforts would be considered futile. In addition, nurses supported the withdrawal of treatment as an end of life option especially when desired by the next of kin or patient. Family and patient input was seen as essential in the DNR decision. In addition, they indicated that factors such as family/patient wishes, physicians, quality of life, and severity of illness, co-morbidities and age all influenced the DNR decision. The nurses believed that honoring the DNR status promoted dignity at the end of life. The DNR designation was viewed as a deterrent of aggressive therapy,

(P1): Because of the status, we all kind of had a controlled situation where we just uhh, made her comfortable, and let the course take its course you know? And the doctor was aware and he said, "well that's all we can do at 3 in the morning, we're not gonna intubate, we're not gonna send her to ICU" 'cause this is what she wanted. She didn't want any of that. So we did, we did that. That was something that, had it been a no code, had it been a full code, then we would have done a lot more of course, but, we just hush, made her comfortable.

Experienced nurses felt that sometimes medical plans were too aggressive in light of the patient’s severity of illness. Nurses often questioned the ethical implications of aggressive therapy for elderly dying patients with a futile outcome,

(P7): It feels, sometimes, it’s, it’s hard. Like you want to intervene you know, in an ethical point of view right? Like, why are we transfusing this patient? Why are we poking this patient? Why do they have to go through this (inaudible) when we
all know that...you know...that’s what’s going to happen anyways. Like if a patient’s 99 year old, or 95 years old, what do you have to subjected to that kind of, uh, you know procedures.

Although, they questioned the ethical implications of aggressive therapy, the nurses still felt it was their duty to respect the decisions and provide the best quality of care.

In summary, the conceptualization of DNR was composed of descriptions of how the participants perceived and defined DNR. The nurses provided specific examples of the definition, which stemmed from their practical experience as well as hospital policy guidelines. The nurses highlighted the ambiguity of the term despite the recent hospital policies and initiatives. The different levels of interventions in the new hospital policy were perceived to be both positive and conflicting. In essence, the nurses recognized the need to clarify the interpretation of DNR in clinical practice and acknowledged the complexities of the DNR decision making process. The nurses believed that DNR orders were written when the quality of life post CPR would be poor. Factors such as family/patient wishes, physicians, quality of life, and severity of illness, co-morbidities and age were considered to influence the DNR decision.

4.3.2 Nursing Role and the DNR Designation

Nursing role and the DNR Designation is the second theme I developed. The nurses described multiple experiences relating to how DNR decisions were made. These experiences pertained to how patients or families were involved in determining the DNR decision, the circumstances in which decisions were made, and how they perceived themselves in the DNR decision making process. The nurses identified how they communicated with the family and physician in relation to the DNR and how they acted as advocates for the patients.
4.3.2.1 Nurse Experience with DNR

All the participants acknowledged the increasing number of DNR designated patients under their care. Some nurses attributed the increasing number of DNR patients on their units to the population that their hospital served, the overall longevity of people, illness trajectories as well as enhanced public knowledge about advance directives. The nurses indicated that generally older adults with a poor prognosis were the first to receive DNR orders. One nurse commented,

(P1): Increasingly most patients come in with DNRs already, and if they're not, if they come in with a full code status, they're quickly made to be DNR after a while, after there's a prognosis that they're not going to improve very much, or, they're very very elderly, ummm, and there's a lot of co morbidities, generally they get changed to a no code from a full code. but generally the patients we see are DNR. The elderly patients.

She further indicated,

P1: I think that most of the decisions for DNR are, are, are made with good reason, good reason and they make sense the majority of the time, and the patients that I see in my type of nursing which are often elderly, a lot of co morbidities who are just very very sick at the end of their life. So it makes sense to me.

Collectively, the nurses felt that age was a leading factor in the DNR decision, in addition to co-morbidities, patient and family wishes and overall health outcome. Although age was discussed as primary aspect in the DNR decision, the nurses stressed how the complexities of the DNR decision have grown; each patient case is highly individual. They believed that DNR orders were “no longer black or white” and that health care providers need to look beyond age based assumptions. As one nurse explained,

(P4): I find as a rule, most of my patients over, say, eighty, eight five, generally have been DNRs. Its also evolved in that it’s also about the health of the patient going in, so the family...it’s complex.
Some nurses commented on their assumptions related to age and DNR. In particular, they discussed how they presume that older adult patients are more likely to opt for a DNR status as they probably are more “ready to go” in comparison to younger patients. In addition, some believed older adults physically cannot withstand invasive medical procedures, and therefore should always have a DNR status.

Most nurses had positive experiences caring for dying older adults with clearly defined DNR statuses. Positive experiences were attributed to the nurses’ sense of control of the situation, reduced anxiety, clear communication with the entire health care team, as well as family support. The nurses felt that with the DNR status allowed them to honor the wishes of their dying patients. Nurses identified that a clearly documented DNR status, with the desired intervention level, allowed them to provide the best care possible within that situation.

Two nurses had negative experiences whilst caring for a DNR designated patient. One nurse ascribed her negative experience to unrealistic expectations of family members of their dying loved one and the lack of support from management with handling verbally threatening family members. The nurse explained,

(P4): The sons were freaking out, I thought I communicated well with them, like, this lady is a DNR. And so, I thought maybe they don’t know that she is, so we went through the whole thing and what that means, and she was, like, have you had the doctors talk to you about your mom’s condition? Yes. So they knew that she was getting...she’s...not going to get better, yes they knew that. So it kinda went like there was a total...ummm...I understand that they were upset that their mother was dying, but there was like no acceptance that that was the way she was heading. They didn’t...they, we talked about the DNR status, yes they wanted to keep that, because I thought maybe there are times where it’s appropriate to change from a DNR back to a full code no matter what I think, even though...But no no, they want to keep her a DNR because that had been their mother’s wishes and they were honoring them.
She further stated,

(P4): Like, you do a good...you do the best that you can do and you do it...above...over...than what’s expected of you. I didn’t need to take that patient, I could’ve hoisted her off on that other [nurse]...you know I could have called in sick. You can see this, you know, whatever, but you do the best that you can do and then you get, you know, this, but, in...in uh...to make a long story short, mother was gone. They did an autopsy because these sons were just freaking out. What the issue, I don’t even know what their issue was, I really don’t, it never made sense, because they were totally irrational guys.

The nurse further revealed, in addition to the lack of managerial support in this case, she also lacked the communication skills and possibly competency to deal with anger from families.

The other nurse related her negative experience when a well-established DNR order for a dying patient was reversed due to family pressures. The nurse expressed her anger and grief for the patient as she felt the dying wishes of this patient were not honored and he could not die with dignity.

(P6): They put him in critical care, they put a tube, like a central line in his neck, put a tube everywhere you can, and he had thirty minutes of what I believe would be hell for somebody who just...had had enough, you know? So it’s like, like...he’s a DNR...It sucked. I was so upset like I cried, because it just like, that was horrible, like, you know, like, he made a decision before he came into the hospital, he made, you know, that was his wish

Many nurses described how these negative experiences followed them home. These nurses thought about how they could have cared for the patient “better” on their time off. These experiences impacted nurses emotionally and physically.

4.3.2.2 Nurse Communication/Conversations in Relation to DNR

There was an overwhelming agreement amongst the nurses that the primary physician made the DNR decision in collaboration with family members. Participants stressed that nurses
did not have a large role to play in the DNR decision, as it was ultimately the physician’s responsibility to sign the MOST form. This form outlines medical orders for scope of treatment and advance care planning decisions. Nurses spoke of how the outlook of the physician on end of life matters influenced when and how the DNR order was made. As one nurse explained,

(P6): It would be nice; I don’t think it’s possible. It’s too many...decisions. But it’s all dependent on each doctor. Some doctors like doctor [name redacted] you know, he’s so kind and sweet when he goes and talks to people, and he doesn’t judge them by their decisions and I feel he takes the time to talk about and going through the form with these patients and their families. Whereas other doctors are like, “do you want to be...do you want a tube shoved down your throat? Do you want CPR? If you don’t, here, sign this form” like it’s just, I think it’s the way they approach it. Because in Emerg everything’s really quick and...I don’t...that’s where the DNR form starts, right? In Emerg. And I feel like there’s not enough time to talk about it, and there’s not enough, like, understanding about, I feel like a lot of patients don’t understand it or have time to digest it. So, but like, once you’re up on a medical ward that status is kind of already addressed. But it can be re-addressed with family... yeah

This nurse further argued,

(P6): Some doctors are super, like, you know? Like, oh their potassium is low, put an IV in them and give them some potassium IV, it’s like, well, you know, they don’t want that, they want to just...you know, the family doesn’t want it, they’re on their way out. But some doctors are like, “yeah, like, here’s some morphine, ordered every hour, give it every hour if you want, here’s scopolamine”, like, some doctors are like, “they’re dying, lets make them comfortable” and give them, like, tons of morphine orders. Whereas some, other doctors are like, they don’t even think about pain, they don’t even think about, like, respiratory distress they’re just like, “okay, they’re dying”. So I think a lot of it is directed by physicians. And then, nurses, unless you’re a really good advocate and can stand up to a doctor, you really can’t [change anything so you] just...[take a seat in the] back row.

Nurses found that the doctor’s held immense power in influencing the DNR or Full Code decision through their explanations to the family member. In addition, the outlook of the physician on death and dying also determined the interventions and shaped the nursing care for patients. New nurses felt these physician perspectives were so strong and over powering that
they could not challenge them, which discouraged nurses from being effective patient advocates. Some nurses found that this created feelings of resentment towards particular physicians and derailed them from working together as a team.

There were mixed perceptions of the nurse’s role in the DNR decision. Some nurses felt that as a profession nurses do not get a chance to talk about DNR as it was not in their scope of practice. Some nurses expressed their fear about giving incorrect information about medical interventions and health outcomes to family members. These nurses were concerned that they would confuse family members through inconsistent information which would cause conflict amongst the health care team. Some nurses believed that their role was limited to following the doctor’s orders, and to implement the outcome of the DNR order. For example, one nurse stated, “I just feel like you don’t have a lot to say as a nurse when it comes to like, DNR status.” Another nurse explained that the doctor and the family “are the ones who are involved in the DNR decisions. We just sort of, you know, [support] where they’re the ones who signs the DNR form, so they’re the ones who make decisions.”

Although, the nurses believed they did not have a direct role in signing the DNR form, the nurses stressed their role as a patient advocate. Many nurses described how they brought the code status issue to the attention of the physician.

(P3): I’ve not been part of the conversation, but I’ve always brought it up when I see a person that is full code, and, it comes to the point where they look very dire in their state of health, I mean, we’ve, we have had to bring it to the doctors attention, or the family’s attention, you know, umm, you should have a conversation with the doctor regarding what you want to take the...you know...how far you wanna take the, the care for your family member.
Nurses felt their input generally was well received from the physicians and they were effective in influencing the DNR decision because of their continuous contact with the patient and family members. They believed they understood the patient’s values and beliefs and were able to successfully advocate and communicate to the health care team on the behalf of the patient and family. One participant described her role as a liaison.

(P4): I think the nurse has to be a liaison, because we’re there all the time, and sometimes they just need to see a couple days of what’s happening...ummm...you know that uh...and then you might, and that might, they might come to you then and say, you know...you can talk through those, and they’re upset to see their...father in so much pain and you can talk about...then you might be able to talk about keeping them more comfortable. But it will mean, umm...we’re now focusing on how are we gonna...we’re now focusing instead of life, we’re sort of focusing on death.

Nurses discussed how advocacy is highly dependent sometimes on nurse’s age and experience. They suggested that years of nursing experience promoted confidence in initiating discussions with the doctor and family.

The nurses also spoke of their responsibility in discussing DNR and related care interventions with family members. Nurses gave descriptions of how they encouraged family members to speak to physicians about their loved one’s code status. Due to the lack of time, and pressed circumstances, nurses felt like many basic questions of family members were left unanswered. Nurses spoke of their educational conversations with the family regarding the various DNR interventions. One nurse explained,

(P5): DNR means you have to explain it to them, education, because they don’t want to hear the word comfort care from you. So if you’re telling them about DNR, because, for me, DNR already have a comfort care part in it, you not just going to do invasive treatment, but you still making, giving them symptomatic treatment just to make them comfortable. They can still have oxygen, they can
still have feeding tube going, we’re monitoring their output. They have intravenous going as well. Plus if patient’s able to eat, we’re still feeding them, [inaudible], and dietician is involved, physician, physiotherapist is involved. So we’re doing a lot to make their life longer and more comfortable. So all we’re not doing is just compressions on them when they’re deteriorating,

Nurses often clarified the definition and misconceptions related to DNR for anxious family members. The nurses indicated that having these conversations helped eased some of the associated angst with DNR. Many nurses discussed at length how they reinforced to family members that their loved ones would still receive the best care possible. One experienced nurse indicated how it was extremely important to her practice to be “frank and to make sure” that the family understood the long-term implications of having an elderly patient resuscitated. More experienced nurses indicated that conversations or discussions were highly dependent on the family’s needs, receptivity, attitude and understanding of the patient’s overall prognosis. They found these discussions highly rewarding and beneficial in implementing care interventions for patients.

4.3.2.3 **Nurses Upholding and Respecting Patient/Family Wishes**

Nurses identified themselves as seldom directly involved in the DNR decision but strongly required to act in a role as a patient advocate. All participants emphasized their duty to respect family and patient wishes in regards to the chosen code status despite their own beliefs. Nurses shared their experiences in which they questioned the viability of aggressive medical interventions for futile cases. The nurses often felt emotionally frustrated and morally torn at the decisions made for their patients. One nurse explained,

(P4): You know, it’s a fine line to walk, and you do make judgements whether you want to or not. Whether you think personally that they [patients] should be, or
shouldn’t be, [resuscitated] you know? Like, probably more than anything, there has been a number of cases where...umm...realistically they shouldn’t be. They are for all the wrong reasons, but that’s not my decision to make. And so you have to nurse and not, you know, the...if...it depends on the relationship you have with the family, it depends on a lot of things.

Nurses indicated that despite their own personal beliefs and experiences they still cared for the patient to the best of their ability and often reflected upon the difficulty of the situation from the perspective of the family members. The nurses recognized the various cultural features that influenced DNR decisions. One nurse in particular, spoke of the cultural devotion she believed was given to the elderly in some Asian cultures. In her experience, she had seen many Asian families struggle to maintain aggressive therapy for their loved ones. The nurses specified that when families made an informed decision regarding resuscitation despite a poor prognosis that nurses generally still supported the families’ decision and practiced accordingly.

In summary, the nurses provided varied perceptions of the nurse’s role in the DNR decision. Some nurses indicated that they were seldom involved in the DNR decision as it was beyond their scope of practice and considered the primary physician responsible for the DNR decision. Other nurses revealed that they were in an advantageous position to advocate for the best interests of the patients and often initiated discussion and conversations with the family for the direction of care. More experienced nurses were able to act as a liaison with the family, the patient and the rest of the health care team in establishing the care goals. These nurses believed they were effective in influencing the DNR decision. The nurses failed to see their role laid out in the new DNR policy. Despite, their personal beliefs and experiences the nurses stressed they respected the patient’s and their families decision regarding the code status.
4.3.3  **Context of Acute Care**

The context of Acute Care is the third theme I developed. When I asked the nurses about how the context of acute care influences nursing care, the nurses relayed multiple experiences and practice descriptions of their care in relation to code status. The nurses identified mixed views of how the code status impacts their nursing care of patients on their units. The nurses described morally distressing situations that affected how they provided care and equated certain complex characteristics of the acute care climate that furthered their moral distress. In this study, nurses defined moral distress as something that occurred internally or externally either to themselves, the system or to others. For example, many nurses associated feelings of anger towards one’s self, diminished self-esteem and burn out. They also associated some feelings of frustration and dismay towards others particularly, towards some patient family members. This moral distress was heightened when they felt like they knew the “right thing to do” but institutional constraints made it impossible for them to act upon that desired course of action. This theme illustrates the complexities of the acute care nursing environment.

4.3.3.1  **Nursing Practice in Relation to Code Status**

When initially asked about nursing practice and code status, the Registered Nurses stressed that the code status “did not matter” and that it “did not influence” their nursing care and practice. However, further into our discussions, the nurses revealed varying perspectives and descriptions about their patient’s code status and their nursing care. The nurses emphasized that patients were given safe and ethical care irrespective of code status. As one nurse explains,
(P1): I give them all the same kind of, all ethical, all safe, all within my scope care that I give for everybody, with or without a DNR, in my day to day care. Things tend to change when things go, when a patient deteriorates, but in the day to day when they're not nothing will change that for me.

The nurses indicated that they were consistent in the nursing care of both full code and DNR patients. They explained when patients started to deteriorate their nursing care interventions changed and reflected the code status. More experienced nurses explained that DNR patients were not denied of basic nursing care; nevertheless they prioritized their nursing interventions and focused more on the full code patient who was “sick”. One nurse explained how she organized her day based on health needs while being cognizant of age.

(P6): I treat all my patients equally and, even in the morning when I get a report, I actually don’t take their DNR consideration into status...like...into...their DNR status into consideration because it’s basically who needs me more right away, so if somebody is in a pain crisis and they’re DNR I will still see them first, or if they’re short of breath, I will still see them first. I think maybe if I had a younger person who was having short of breath and somebody who was a DNR who was having short of breath, yeah, I think I would tailor more to the young person who does want to be a full code. So if...I haven’t actually been in that situation, but I feel like when I do my...kind of checklists in the morning I treat everybody equally

The age of the patient also played a major role in how nurses organized their care for their patients. There was consensus amongst the nurses that patients who were full code and younger received more medical attention, detailed assessments, and invasive procedures compared to older DNR designated patients. It was assumed that older adults with a DNR status were more likely ready to die in comparison to younger patients. As one nurse explained, if the person [has] a DNR status [and] is short of breath that’s, and it’s caused naturally, that’s...they’ve already come to that conclusion. They want to die naturally.”
Some nurses shared that they were more proactive, provided more detailed assessments and were more vigilant in nursing documentation and connected more frequently with physicians when they cared for full code patients. These nurses attributed their heightened sense of attention to their fear of an impending Code Blue and possible hospital investigation. One experienced nurse shared her perspective about the anxiety regarding a sick full code patient,

(P8): I feel like everyone should be treated equally whether they’re DNR or full code, they should have the same level of care right? But I think it’s just...it’s not said necessarily, but I think it’s still in the back of everyone’s mind, “oh my god, they’re full code, and they’re sick, okay we need to do something here” right? And, umm, I find a lot of people that are full code and they’re getting sick they get sent to ICU way faster than if they’re DNR because nobody wants to have to deal with that on medical units right? They want somebody with a higher level of nursing to deal with.

The nurses described many “unspoken rules” of acute care that related to how younger full code patients were medically treated. The nurses suggested younger patients were generally sent to a higher level of care rapidly. It was the duty of the primary nurse to advocate relentlessly for deteriorating full code patient until the patient was sent to a higher level of care. Most nurses felt a sense of relief when their sick patients were sent to ICU as they knew the patient would receive “better individualized care”.

Another commonly held perspective in relation to code status connected to the level of comfort and relief felt by nurses caring for DNR designated patients. The DNR code status was viewed positively. The nurses felt they were protected from any blame of inadequate nursing care with their DNR patients. Although many nurses stressed that DNR did not mean “do not care”, they indicated that these “unspoken rules” suggested that if a DNR patient deteriorated and eventually died, that it was “okay” as DNR patients were emotionally comfortable with
death. The end of life care wishes of the patients would still be upheld as to “no resuscitation”. Although, the nurses were aware of the multiple dimensions of DNR as per the hospital policy, many nurses equated that goals of DNR were related to comfort care, where patients were still medically and symptomatically managed to a comfortable degree without overzealous aggressive therapy. The nurses believed that the DNR status dictated the degree of aggressive management required for a sudden decline in a patient’s condition.

In contrast, some participants offered that DNR code status pushed them to perform more detailed assessments, liaise more frequently with the doctors and family members and initiate many nursing led interventions as they felt more responsible for caring for a DNR designated patient on their unit. The primary nurse was still highly accountable for the outcome of the patient. One experienced nurse shared her experiences caring for DNR designated patients on her unit,

(P5); But on the other side, now, with five years’ experience working in a medical unit, when [a] patient is full code and I can press the button and call the team and they can do everything, but when they’re DNR, now I feel more responsibility on me. Because I’m not allowed to call the code, but, I have to do a proper assessment, because I’m the one who’s going to assess and tell the doctor to get the treatment going to make them comfortable... So if patient deteriorating, the [it] will be up to me how I assess a patient and give report to doctor and then get the treatment going. Because if [the patient is a] full code obviously deteriorating I can just press the button and call the team and then, they can get transferred to ICU, they’ll be on cardiac monitors. These patients [with a DNR status] are not going to be on cardiac monitor if they don’t have orders

This nurse described the change in her belief system and practice regarding the care of DNR designated patients from a less involved to a more involved approach from her novice days. She further stated that she has to “do a lot more for a [DNR] patient than for a full code patient”.
4.3.3.2 Nursing Moral Distress in Acute Care

The nurses described multiple characteristics of the acute care environment which influenced their nursing care and practice for their patients. The moral distress was intensified for nurses caring for patients who were dealing with end of life issues. The participants perceived that the characteristics of the acute care environment propelled their moral distress.

4.3.3.2.1 Lack of Beds

It was clear that the nurses believed that the acute care organization negatively affected nursing care. Nurses indicated that the impersonal and crowded environment of their acute care units was harmful and impeded their nursing care of dying patients. The overall lack of beds, in which patients are placed in hallway beds or placed in rooms with other patients irrespective of age, diagnosis and prognosis, was perceived as unethical and frustrating. Many nurses questioned the limited number of palliative bed and private rooms. The lack of privacy in acute care was seen to jeopardize grieving needs of family members.

(P6): And also, like, like having room. Like you know, certain patients should be going to the palliative ward because that’s where they get the care, that’s where they get palliative management with like, nausea, bowel movements, all that stuff, but like, there’s no room, so they stay on a medical unit, and we’re...I feel like we know the basics of palliative care and end of life care, but we don’t know enough to make somebody extremely comfortable, or families. Or like, yeah, it is kind of crappy when you’re in a four bed ward with other families, and like, buddy next door is going through alcohol withdrawal, and the person over there has got C-diff. That’s not a nice environment to die in.

The nurses indicated that medical needs of the patients dictated which patients they attended to first and many times, end of life care in acute care was viewed as the last priority. The nurses perceived that dying patients were neglected in acute care.
Many nurses felt a high degree of guilt and voiced disappointment with their management for not advocating for better quality patient care. They also viewed their management as being helpless due to aging infrastructure of their hospital, increasing acuity of the patients in addition to the lack of beds in the entire hospital. The nurses also spoke of the larger contextual forces that shape the organization of acute care. They acknowledged how mounting pressures of cost reductions have led to many acute care sites to reduce their numbers of practicing registered nurses due to bed reductions, unit closures and discontinuation of publically funded hospital services. One nurse expressed hopelessness in the improvement in end of life care due to the lack of beds.

(P8): Well not good, but I mean, there’s not really a whole lot you can do, right? We just have this old building and there’s...no funding to, you know, change it, so, they’re trying to work with what we have it’s just not great, and it’s not great for infection

The nurses strongly believed that there was no “quick fix” to this essential issue of lack of beds in acute care. In addition, they suggested that this issue needs to be dealt with from a social and structural perspective.

4.3.3.2.2 Lack of Resources

The nurses viewed the lack of resources in acute care as an impediment in their nursing care. They described situations in which they spend a considerable amount of time looking for and obtaining the necessary equipment or supplies to care for both their DNR designated patients and Full Code patients. The nurses also described multiple scenarios in which they would spend time trying to connect with educators or other personnel to discuss specific questions relating to nursing care and interventions. Nurses viewed this constant struggle as distressing as it “wasted a
lot of time” and prevented them from “being with their patients.” Many nurses viewed acute care as “ill equipped” for caring for dying DNR designated patients in terms of supplies such as medications. As one nurse explained,

(P3): If you like...just for example, if this is a patient that has lots of pain, and you have to be in there giving pain meds every one hour...(pause)...I mean, even on a palliative unit you have, you’re well stocked on that. On an acute unit, you don’t have that much pain meds, or on an acute...

More experienced nurses recognized that funding had a direct link to the amount of resources allocated for their units. These nurses often attended unit meetings to appeal for more equipment such as bladder scanners, lifts, and vital signs machines which they believed were fundamental to better patient care.

4.3.3.2.3  Lack of Staff

Nurses regarded lack of staff and heavy workload extremely stressful. The nurses shared multiple experiences in which they often worked “short” on their units with critical patients. Nurses viewed these working conditions as unethical, emotionally and physically disturbing. This also influenced their sense of control over their work environment. Having a heavy workload and doing too many things at once contributed to errors, as did fatigue associated with heavy workload. The nurses stated often errors were discovered when workload was high. In addition, the nurses believed that patients were not checked as often and patients had a higher incidence of falls when they were working short staffed. Nurses indicated that “working short” promoted a lack of continuity of care and treatment plans for dying patients. The nurses also emphasized difficulties in dealing with patient and family suffering with inadequate staffing
levels. The nurses suggested that the approach of reducing nurses to maintain costs comes at a high premium in that it jeopardizes quality of care, nursing morale and practice.

4.3.3.2.4 Lack of Time

The lack of time was a prevailing negative issue for the nurses in acute care. Nurses felt like there was “never enough time” due to the insurmountable number of tasks they had to perform. Efficiency in nursing was viewed as the ideal in acute care. Nurses believed that they were judged on how fast they performed tasks irrespective of patient feelings and needs. This ideal of efficiency often left nurses feeling emotionally tormented, over worked and overwhelmed. One experienced nurse explained this had negative consequences for patients as well,

(P7): It’s just because, you know, we’re overworked, we don’t have enough time to spend care for the patient. Sometimes we kind of like, such in a hurry, you know, to finish the job without providing, you know, patient is dying, or patient is very sick, or patient is DNR, that we kind of, you know, they’re very frail, they are, but we are sometimes in a rush, like we do personal care that sometimes we don’t, without, you know, having to do it. Sometimes we do it so fast that we actually causing more discomfort to the patient.

Some nurses suggested they had to lower their practice standards in order to deal with pressures associated with efficiency. By lowering their practice standards nurses felt they had to engage in substandard practice in order to facilitate faster care delivery.

4.3.3.2.5 Conflict and Communication

The nurses described several incidences where they felt tension and anxiety when there was a lack of consistency in communication. They indicated three communication issues. The
three most frequent conflict issues were between nurses and physicians, staff and family members and among family members. Many nurses felt like physicians were not aware of the overall prognosis of the patient. Other nurses believed that some doctors did not bother listening to the nurse’s perceptions. One nurse described her experience,

(P7): One of it is just communication between the doctors sometimes. That’s what I find. I think that’s what is frustrating sometimes, because sometimes patient and, I mean the doctors and nurse they don’t see eye to eye, like, we as a nurses, we see the patient all the time, we know what the conditions are, but the doctors sometimes they, they probably going to spend a few hours, a few minutes the most, see a patient. So they don’t really know what’s going on, like everything is based on what they see on the lab results, or the test results, and, uh, I think that’s where I see that needed improvement, that doctors should see more of the patient, as a patient, not as a patient where they just only read, you know, from the chart, but to see what’s really going on...

The nurses suggested that conflict arose between health care providers, when communication was lacking on the DNR order, or the appropriateness of the DNR order, the way the topic was discussed with family and the timing of the discussion. These nurses found it frustrating when physicians refused to sign the DNR form especially in futile cases. They felt unethical in subjecting to patient to such invasive procedures when the patient was clearly dying. One nurse commented,

(P7): It feels, sometimes, it’s, it’s hard. Like you want to intervene you know, in an ethical point of view right? Like, why are we transfusing this patient? Why are we poking this patient? Why do they have to go through this (inaudible) when we all know that...you know...that’s what’s going to happen anyways. Like if a patient’s 99 year old, or 95 years old, what do you have to subjected to that kind of, uh, you know, procedures.

Often times, the nurses found themselves wedged in between the expectations of the family members and opposing expectations of the health care team. The nurses indicated that this occurred when the health care team thought the patient should have a DNR order and the family
refused to sign the consent. This led nurses to be the brunt of family frustrations. Some nurses felt like they had to justify all their nursing practice to family members who were not ready to accept the DNR order. One nurse shared her experience of how she wanted to avoid conflict with family member, who was in denial,

(P4): Like, we had, we’re making her comfortable. I was walking that line between...whatever, and keeping the son happy. I didn’t do as good, as good nursing to that mother as I could have, I would have kept her a little bit more comfortable, but this was one where there was real fear that came in.

The nurses described conflict among family members about making a decision about DNR status. Some experienced nurses indicated that they worked as mediators between family members to try to understand their feelings about DNR and helped them give insight into the various perceptions of the DNR status. One nurse explained that she “felt emotionally taxed” when there was a lack of consistency in communication amongst family members as it made caring for the patients extremely difficult and confusing.

In summary the context of acute care was revealed through descriptions of what influenced nursing care of both DNR and Full Code patients. The nurses stressed that patients were given safe and ethical care irrespective of code status however nursing interventions were prioritized for full code patients. The nurses indicated full code and younger patients received aggressive treatment in comparison to older adults. Nurses described how the characteristics of the acute care environment propelled their moral distress. The nurses indicated that the lack of beds and the crowded environment impeded their practice. The lack of staff and time were seen as prevailing negative issues in acute care. This promoted a lack of continuity of care and treatment for dying patients as well as lack of support for families and patients dealing with end
of life issues. The emphasis on efficiency in acute care left many nurses to feel burnt out. Finally, the conflict in communication between nurses, physicians, staff, and family members and amongst family was viewed as confusing and frustrating for nurses. Nurses found it especially frustrating when physicians refused to sign the DNR form especially in situations that they saw as futile. Some nurses felt emotionally tormented subjecting patients to invasive procedures when the patient was clearly dying.

4.4 Barriers to Nursing Practice in Relation to DNR Status

The fourth theme I identified was barriers to nursing practice in relation to DNR status in acute care. Although, the aforementioned themes and subthemes can be viewed as barriers to nursing practice in relation to DNR status, the nurse’s in my study separated and discussed the following as barriers to their daily practice. When I explicitly, asked nurses about of what they perceived as barriers to their practice the nurses revealed subthemes of physician’s orders, family members and lack of nursing experience in end of life. The nurses pointed out that their practice and care of older adults did not occur in isolation but was influenced by numerous relationships. In particular, they believed, that nursing care and practice was dependent on relationships between other nurses, patients, the health care team and the socio-political climate of the health care system.

4.4.1 Physicians/Orders

The nurses viewed physicians and their orders as leading barriers to their practice. They found that treatment plans for DNR designated to be highly influenced by the leading physician.
The nurses explained that physicians are not aware of the end of life care wishes of their patients or family members due to the lack of time. One nurse described her experience,

(P8): Like, on long weekends there’s lack of doctors. Like, we have a hospitalist that comes and he has, he or she has, you know, three or four different units that they have to go to, so you might them for an hour or two in the morning so, and somebody is sick or that sort of thing during the end of the shift, they’re busy in somewhere else, they won’t come back unless it’s an urgent matter right? You’ll talk to them over the phone and they’ll kind of snub you, you know?

This lack of knowledge is evident through their aggressive treatment orders, which need to be carried out by nurses. Some nurses believed that these orders written in haste have been unrealistic and more detrimental to the patient. Other nurses explained that the attitude of the doctor on end of life issues also influences orders and thus shapes how nursing care is conducted. More experienced nurses expressed their frustration on their lack of a direct role in DNR discussions. This physician dominance led many newer nurses to disregard their own judgement and knowledge of the patient wishes. As a result, the nurses described feeling discouraged in their practice.

(P6): The barriers? Probably, like the physician’s orders. Orders from physicians, the plan of care directed by the doctors. Umm. (pause). Like barriers in the way like we don’t really get to discuss...have that conversation with the family, or the patient themselves really. We don’t get a really good understanding to see what they want. So I think, you know...I feel like if pain medication wasn’t ordered, I felt like maybe the physician would have had the conversation with the patient or the family and they decided not to. So...but like, if I’m like, “oh you know, are you in pain, do you want your mom to have morphine shots on her way out?”...Like, I’ve never had that conversation with somebody because...yeah. So I think that’s a barrier. Kind of this un...talked about ground between patients and DNRs and nurses.

In general, several nurses associated physician shortages, care perspectives and the overall lack of time with an insufficient understanding of patient and family wishes. One nurse suggested that
if “doctor’s listened to nurses more in terms of patient wishes then unwanted treatment procedures could be avoided”. Nurses indicated that they had a better understanding of patient and family wishes than some physicians due to the length of time they spent providing care. In this way, many nurses considered unrealistic physician orders as barriers to their practice.

4.4.2 Family Members

Highly directive and anxious family members were viewed as barriers for nursing practice. The nurses described multiple experiences where they felt over-powered and at times antagonized by family members who had unrealistic expectations for their loved ones. One nurse explained,

(P8): They...they have a certain way that they want their family to be treated and sometimes it’s not in the best interest of the patient so, sometimes it’s...it’s a lot of trying to convince the family this is best for your mom or dad or whatever. And...sometimes they don’t agree with the way you’re doing things or that sort of thing or what the doctors have ordered for this patient.

Nurses explained how they felt fatigued by discussing the plan of care and medical interventions multiple times to the same family member. They felt like their “every move was watched” which negatively influenced their confidence and their ability to perform tasks. Some nurses felt like they were made to “double guess” their own nursing experiential knowledge. Some nurses indicated that anxious family members emotionally drained them and resulted in calling in sick.

The nurses highlighted specific examples of how family members “flip-flopped” between aggressive treatments to comfort care. They gave examples of how some family members “reversed” or “revoked” the DNR order. The reversal of a DNR order was perceived to be maddening and even unethical.
(P3): It’s frustrating because we know, it’s been a long battle to make...to help get this patient DNR, and now we reverse them back to full code, it means everything we’ve done has been undone. It’s frustrating, it’s, you know, and sometimes it makes you feel like, “oh my gosh, what are we doing? Like, honestly, is this even right to do this to this person anymore?” You know. Its, its a struggle for yourself. It’s an internal struggle.

The nurses indicated anxious family members made nursing care of dying DNR patients difficult in acute care. Some nurses acknowledged that this type of heightened anxiety could have been a part of the families’ complex grieving processes and likely exacerbated by resource shortages.

4.4.3 Lack of Nursing Experience

The nurses indicated that lack of experience in end of life issues also acted as a barrier for nursing practice. Many nurses described how nursing experience promotes confidence, better assessment skills and critical thinking, and more efficient liaison with the health care team and family.

(P4): It depends on the level of nursing, I’ve been nursing for twenty years, so I’m totally more relaxed with things than I would’ve been when you’re a brand new nurse so, could be, experience, and again, I think at that pragmatic approach and that realistic thing, I think comes a little bit with, like you start off kind of dewy eyed that you’re going to do...you know...everyone’s going to get better and go home, you know, whatever, you have kind of expectations on yourself so you can get in the way too if that makes sense, right? Like, so at the end of the day it’s gotta be what’s best for them, what’s best for them I guess, and might not be what we think. It might not be what’s best for them to go home. It might be it’s best for them to give up, if they’ve been suffering for, you know, a long time with certain conditions, right?

Many nurses described their experiences being a new nurse, and how they were not able to fully understand the needs of a dying patient. Due to their lack of experience they believed they pushed for aggressive medical treatment to help “fix” their patients without really comprehending the patient’s overall prognosis. Some believed that because of their limited
experience they perhaps caused suffering to their patients. In addition, some nurses explained that it was extremely intimidating for them to question the leading physicians in relation to the plan of care for futile cases.

4.4.4 Lack of Education in End of Life Care

Nurses also suggested the overall lack of awareness of the dying process as a barrier for nursing care and practice. Nurses spoke of the limited education they received in nursing school regarding death and felt they were not prepared for providing end of life care. One nurse stated,

(P6): Death is not really addressed...in school you learn about finances, you learned about relationships, you don’t learn about death. Not that you need to know what happens after death, but just, become more comfortable with the idea, like, living wills, and, you know, and, and having an open conversation at the table, with family and stuff.

In addition, several nurses suggested that they had inadequate knowledge about pain management and how to help families through the grieving process. Despite the importance placed on providing comprehensive care to the dying patients which includes managing distressing symptoms, nurses reported a fear of hastening death through administration of analgesics for pain. Many new nurses believed that they were unable to provide family members with adequate explanations when their patient entered the dying phase. Nurses believed that this was a major obstacle in the provision of high quality end of life care.

In summary, nurses reported complex barriers to their ethical practice in relation to DNR orders. The lack of a holistic perspective of the dying patient on the part of the physician was seen as barrier to nursing practice. The lack of time in conjunction with the lack of knowledge of the patient’s wishes has led physicians to write what nurses perceive as unrealistic and
detrimental orders. This common occurrence has created morally distressing practice environments for nurses as they are required to carry out these futile orders. Highly directive and anxious family members were viewed as barriers as they often undermined nursing knowledge and confidence. The nurses found that this lack of confidence directly affected the quality of care for the dying DNR patient. Moreover, such communication conflict likely also worsened the families’ grief processes.

Lack of nursing experience was viewed as a barrier towards practice. The nurses felt that experience encouraged refined assessment and critical thinking skills and confidence to connect with health care team members. The lack of awareness and education of end of life care was seen as a practice barrier for nurses as nurses reported feelings of inadequacy in symptom management and supporting family members through the dying process. Misconceptions related to pain management detracted from providing sound end of life care.

4.5 Facilitating Factors to Nursing Practice in Relation to DNR Status

In addition to barriers to nursing practice, nurses described factors that currently assist them or will assist to provide safe and ethical care of DNR designated patients. Nurses described facilitating factors positively as they viewed these factors leading to practice improvement and better patient care. The subthemes included communication with the health care team, education, team work and higher nurse to patient ratios.
4.5.1 Communication with the Health Care Team

The nurses indicated that communication with the entire health care team was crucial in supporting nursing practice. All the nurses were aware of their significant role in patient care, recovery and comfort however they also stressed the vital role that other interdisciplinary team members play in the hospitalization process. These fields include social work, physiotherapy, speech and language and dietary. The nurses explained that having important information projected to all members of the health care team allowed consistency and efficiency of patient care. The nurses stressed that all members must understand the meaning of the DNR status. This also reduced the conflict, confusion, moral distress, and allowed many nurses to be vigilant of the patient’s needs especially with end of life care. The nurses stated that sharing care perspectives and values with the team promoted better organization of the unit and reduced errors. One nurse stated,

(P6): Yeah, just like working with people who have the same outlook on it, like if your partner, like you know, if I go out on break and I was concerned about a patient even though they’re a DNR status it would be nice if, to communicate and have the same values as the person who’s taking over to be like, so and so is sick, they’re a DNR, but like, you know, if they’re uncomfortable, do you mind giving them some morphine or something.

Nurses believed that discrepancies in explanations about the meaning of DNR can confuse patients and families which can undermine their trust in the health care team. Therefore open communication must be maintained with the entire team.
4.5.2 Education

Nurses believed that education about DNR designations and end of life care propels nursing care and practice. The nurses stressed that because they are on the front line of clinical situations where DNR understanding and knowledge is key to patient care, they must have better formal education services. Nurses indicated that they needed more education on the new hospital policy so they could answer family member’s questions. One nurse stated,

(P5): So, I guess, probably the more support and more education, regular inservices about DNR and full code, will help staff members to understand, and, on the other side, how to...educate families in learning this whole help as well

They believed more opportunities for educating nurses about end of life need to be created starting from nursing school, and followed through to the clinical setting.

The nurses recognized how formal education about DNR can promote better application of the new hospital policy, protocols and guidelines as it will allow discussions about specific end of life scenarios. The nurses believed these types of educational opportunities will advance their clinical expertise, critical thinking skills and will allow nurses to learn from each other. The nurses discussed how education of family members and patients about DNR takes time, and involves repeated explanations about interventions. Therefore as one nurse stated, “So if you’re not well informed how you can teach somebody else?” They acknowledged that without education and discussion of the DNR status, change of nursing practices and follow-up of morally distressing situations related to end of life would not occur. In addition, without committing educational efforts to this area the nurses believed that physician dominance will continue to prevail in DNR discussions and decision-making.
4.5.3 Teamwork

Team work and support were seen as facilitators in nursing care and practice of DNR designated patients. The nurses described the unpredictability of the health of their patients on their units. This unpredictability led them to refer to the code status of their patients, for medical intervention guidance. During these chaotic shifts, having support from their co-workers was described as essential in providing safe and ethical care. A rapid decline in one patient requires the primary nurse to focus their attention to that patient which can lead him/her to fall behind in the care of other patients, therefore having a supportive team allows for smoother delegation of care tasks. One nurse stated,

(P1): When something goes wrong you're overwhelmed with one person and, and you do need, you know, you're only as strong as your team, so definitely, support from your, from you're in charge first, but more so I find the site leader is a very good support.

Another novice nurse explained,

(P2): Yeah definitely. Yeah. I think in general nursing, umm, it does help tremendously to know that especially as a new grad, umm, encountering new scenarios like that, not only does it give me confidence to make my own decisions and have autonomy in my care, but it also is very comforting to know that there is some senior nurse who has been through all that sort of, confirming what I do, and what I think.

The nurses suggested that having both emotional and physical support allowed them to enhance the end of life experiences of their patients. Nurses suggested a commitment to the “team”, shared decision-making and team valued routines such as turning and repositioning patients promoted better care. One nurse indicated that acknowledging each other strengths promoted competence and confidence on the unit thus improved nursing care practices.
4.5.4 Nurse to Patient Ratio

A higher nurse to patient ratio was viewed as a positive factor in the provision of safe and ethical care to DNR designated patients. The nurses believed that having fewer patients to each nurse promoted better assessment and improved problem solving skills and critical thinking. In addition, they indicated that having fewer patients, gave more time to adequately address the psycho-social needs of the patients which often is neglected. This also gave more time to keeping families apprised of patient’s conditions, educating family members about DNR, and participating with physicians and social workers in initiating discussions of DNR. The nurses also suggested that this lead to less staff burn out and improved staff cohesion levels. Experienced nurses suggested that having more time with their patients allowed them to be more sensitive and supportive of family decisions even if they as nurses they did not agree with the decided care plan. One nurse projected that this would also minimize interpersonal conflict in implementing DNR orders as it would give nurses more time to relay their concerns to the health care team and increase advocacy.

In summary, facilitating factors towards nursing care of DNR designated patients comprised of four subthemes. Communication was seen as crucial in supporting practice. Education was viewed as essential in improving care practices and assessment skills for dying DNR designated patients and for practice improvements, advocacy and support for family members. Team work and support were also associated with propelling better nursing care and practice through delegation, shared decision making and focus on positive team values. The final factor that was identified as facilitating safe and ethical nursing practice was higher nurse to patient ratio, which was believed to increase staff cohesion, advocacy and education.
4.6 Chapter Summary

In this chapter, I presented the findings from the qualitative interpretive descriptive study. I generated five major themes. The first theme was defining DNR which was comprised of the subthemes nursing knowledge/understanding of DNR, hospital policies and directives and nurse emotions and beliefs. The second theme, nursing role and the DNR designation, incorporated nurse’s experiences with DNR, their communication and conversations in relation to DNR as well as upholding and respecting patient wishes. The third theme, entitled context of acute care included subthemes of nursing practice and nursing moral distress. The fourth theme, barriers to nursing practice in relation to DNR status, was linked to the context of acute care and was supported by subthemes of physician orders, family members, lack of nursing experience and lack of education in end of life care. The final theme of facilitating factors to nursing practice in relation to DNR status, incorporated subthemes of communication, education, team work and higher nurse to patient ratios. In the next chapter, the findings will be discussed in the context of current literature. As well, a discussion of the implications for nursing practice, research, education, administration, and policy development will be presented.
CHAPTER 5: SUMMARY, DISCUSSION OF FINDINGS, NURSING IMPLICATIONS AND CONCLUSIONS

In this chapter, I present a summary of the research and a discussion of the findings in the context of existing literature. The implications for nursing practice, education, and policy based on my discussion of the findings are presented, as well as conclusions drawn from the study.

5.1 Introduction

I conducted a qualitative study to gain a better understanding of the nursing care of older adults with DNR designations on medical/surgical units in acute care. The sample consisted of eight Registered Nurses working on acute medical units at one hospital within one health authority in the province of British of Columbia. The Registered Nurses varied in their years of experience, which ranged from eight months to 20 years.

I collected data using a semi-structured interview guide. The hour-long interviews were audio-taped and transcribed verbatim. I also utilized a reflective journal to explain my personal views. I used the criteria proposed by Lincoln and Guba (1985) to develop trustworthiness in a qualitative study to contribute to the rigor and quality of my research study.

Interpretive Description was the methodology guiding the study. I used inductive content analysis to analyze data from the interviews. I developed codes from the data by reading and rereading transcripts and going line-by-line through each transcript making notes in the margins. I used constant comparison to analyze data within and between interviews which resulted in five themes. (1) nurse’s conceptualization of DNR; (2) nurse’s role in relation to DNR; (3) context
of acute care in relation to practice and care; (4) barriers to care; and (5) facilitating factors in providing good care to older adults with DNR designations. Each theme was composed of sub-themes, which further developed the theme.

5.2 Discussion of Findings

Key findings in relation to my research questions, the five themes from my study will be discussed in the context of the literature and the theoretical framework of relational ethics.

5.2.1 Conceptualizing DNR

Nurses in this study conceptualized DNR on the basis of their practical experience, personal understandings, and the hospital’s policy guidelines. At the surface level, all the participants in my study were able to clearly define the literal definition of the term and what nursing actions it encompassed. At this level, these findings contradict other studies regarding the literal definition and understanding of DNR in that nurses in my study were able to articulate that DNR pertains to CPR being withheld at the time of a cardiac or respiratory arrest (Fritz, Fuld, Haydock, & Palmer, 2010; Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). However, when participants were asked to describe what DNR meant to them at a more in depth level, nurses associated DNR with partial palliative care, and the reduction in advanced and invasive medical treatment especially if the patient was an older adult. In this way, these findings concur with the current literature regarding nursing beliefs and attitudes with DNR (Fritz, Fuld, Haydock, & Palmer, 2010; Hilden, Louhiala, Honkasalo, & Palo, 2004; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). The
findings that I have articulated in my study point to a significant degree of confusion in interpretation and understanding on the part of practicing nurses.

These findings have major implications. This lack of understanding in meaning of DNR influences nursing care practices and interventions. First, it is clear that DNR orders are sometimes misinterpreted meaning that nursing and medical care somehow should be reduced, which suggests that patients may be receiving substandard care. Several studies have suggested that this is the case for other nurses and health care providers (Cohn et al., 2013; Fritz, Fuld, Haydock, & Palmer 2010; Henneman et al., 1994; Sherman & Branum, 1995; Stewart & Baldry, 2011; Thibault-Prevost, Jensen, & Hodgins, 2000). At the same time, while nurses in my study stressed that the code status “did not matter” and “did not influence” their nursing care and practice. Further, in-depth discussions revealed that the code status did matter and clearly influenced nursing care and practice. Nurses prioritized their nursing interventions and focused more on the full code patient who was “sick”. There was consensus amongst the nurses that patients who were full code and younger received more medical attention, detailed assessments, more invasive procedures and nursing care as compared to older DNR designated patients. In this way, the findings suggest that DNR orders function as unofficial stop signs to what was deemed as aggressive treatment. These findings concur with the literature. In particular, Fritz, Fuld, Haydock, & Palmer (2010) found that nurses believed that a DNR reduced medical escalation, and frequency of nursing observations, and made it less likely that they would contact the outreach team. The DNR order itself is supposed to only relate to cardiopulmonary resuscitation; it should not impact on other treatments for patients. Unfortunately, these negative practice beliefs could have detrimental repercussions. For example, physicians might be less
willing to fill out DNR forms for fear of diminishing the overall standard of care even if they do not think that Full Code would be appropriate for a particular patient (Fritz et al., 2011), and patients who have a DNR status may receive substandard nursing care and medical treatment (Cohn et al., 2013; Fritz et al., 2010; Henneman et al., 1994; Sherman & Branum, 1995; Stewart & Baldry, 2011; Thibault-Prevost, Jensen, & Hodgins, 2000).

The DNR status was viewed positively by the nurses in this study which corresponds to previous studies (Duke & Thompson, 2007; Ganz, Kaufman, Israel, & Einav, 2013; Giles & Moule, 2004; Hilden, Louhiala, Honkasalo, & Palo, 2004; Jepson, 2003; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). An interesting and relatively novel finding of this study, related to how nurses attributed a sense of relief and comfort caring for patients with a DNR status. The nurses explained that the DNR status provided protection from any blame of inadequate nursing care. These notions were a part of the “unspoken rules” of acute care where if a DNR patient deteriorated and eventually died, that was “okay” as DNR patients were emotionally comfortable with death. These findings again reinforce possible negative care approaches with DNR designated patients. And, of course, it is also possible that in many situations the outcome was as positive as the nurses claimed.

Clearly, these findings imply that DNR can be misinterpreted and care applications can be misapplied, but they also point to concealed negative end of life care beliefs that are entrenched within acute care. New approaches are required to deal with issues surrounding DNR orders specifically maintaining the clarity of instruction but also attacking these underlying assumptions and stigma associated with DNR.
Age was identified as a major criterion for DNR orders in this study. The nurses’ understanding of DNR was closely linked to the patient’s biological age. Similarly, the literature indicates that DNR orders are closely associated with aging (Cherniack, 2002; Costello, 2001). The dilemma about the appropriateness of DNR orders comes into question when the focus is placed on dying older adults (Costello, 2001). Indeed, nurses in my study frequently provided examples of how care is prioritized based on age, and they touched upon age based-assumptions regarding end of life choices. This brings forth questions relating to how older adults are perceived and cared for within our health care institutions during end of life, particularly considering the insidious and pervasive nature of ageism (Rees, King, & Schmitz, 2009) Perhaps older adults are receiving substandard care during end of life based upon their medical and physical fragility. The nurses in my study identified older age, medical futility and aggressive treatment as sources of ethical problems, which included conflict with doctors, peers, family members and lack of staff resources and support.

The nurses in my study also often voiced frustration about how older adults were subjected to intense medical treatment despite their DNR and end of life wishes. At the same time, some nurses’ spoke of how patients should not be treated any differently based on age in terms of medical procedures. These frustrations had underlying ageist connotations in that assumptions about appropriate treatment and care were made on the basis of chronological age rather than careful determinations of individual best interests. Nurses in my study offered multiple justifications for DNR orders for older adults, which included their fragility, multiple existing co-morbidities, quality of life, dignity and comfort associated with the avoidance of invasive procedures associated with DNR. Ironically, the nurses in my study both claimed that
age should not matter, but they themselves used age as indicator for the appropriateness of the DNR order. Regardless, the nurses emphasized that the care of patients does not occur as isolated events; such care is in fact, influenced by multiple relational interactions that are beyond their control. Sometimes care of older adults with a DNR order becomes the lowest on the priority list in over stressed work environments.

Nurses’ conceptualization of DNR was also informed by a new standardized Medical Orders for Scope of Treatment (MOST)/Advance Care Planning policy at the study site. These findings diverge from the current literature which concludes that nurses in acute care are largely unaware of the existence of DNR policies in their particular health care organization (De Gendt, 2005; Duke & Thompson, 2007; Manias, 1998; Smith, Poplett, & Williams, 2005; Thibault-Prevost, Jensen, & Hodgins, 2000, Jepson, 2003). Although, the nurses recognized the importance of having a standardized policy regarding advance caring planning, interestingly, findings revealed that nurses had conflicting opinions about the policy’s role in clarifying DNR orders. Some nurses felt that the different levels of interventions provided clarification for their practice, whilst others found the different interventions levels quite invasive and felt they promoted unnecessary subjection of patients to painful procedures. These findings raised specific questions regarding how DNR policies are interpreted within this overstressed practice context. The nurses in my study were not involved in formulating this MOST policy, which is a gap that is reflected in other literature (Duke & Thompson, 2007; Giles & Moule, 2004; Manias, 1998; Sulmasy et al. 2008; Thibault-Prevost, Jensen, & Hodgins, 2000).

Overall my study has implications for how DNR is conceptualized in acute care, nursing involvement in policy formation and implementation. Nurses must have input into as well as
effective knowledge and understanding of their institutions’ end of life policies. Such input and knowledge allow for better delivery of nursing care, and provides motivation for addressing DNR conflicts. This knowledge also empowers nurses to become more well-informed patient advocates who can effectively exercise their clinical judgment.

5.2.2 Nursing Role and the DNR Designation

The findings of my study correspond with those of several studies demonstrating the very limited role of nurses in DNR decision making process. Ultimately, it is the physician who makes the final decision (Costello, 2002; Giles & Moule, 2004; Hilden et al., 2004; Jepson, 2003; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). Currently, there is no legal obligation in Canada that nurses participate in the DNR decision making process. Findings from this study concur with the literature that nurses view themselves as patient advocates or in a liaison role if they do participate (Costello, 2002; Jepson, 2003; Jezewski, Scherer, Miller, & Battista, 1993; Jezewski, 1994; Manias, 1998; Thibault-Prevost, Jensen, & Hodgins, 2000). The results of my study also point towards the importance of nurses having a legal and clearly defined platform expressing their professional and practical judgment regarding DNR.

An interesting finding from this study related to nurses who believed that they had no control over DNR decisions. These nurses apparently made no attempt to change the focus of care even though they felt morally distressed over carrying out what they saw as aggressive treatment interventions. The nurses who viewed themselves as patient and family advocates described understated strategies on how they influenced and directed the physicians to re-
examine the code status. These nurses usually were older and more experienced nurses, and most importantly, knew how to navigate and work with the various end of life perspectives of the physicians. These understated strategies included consistently reminding physicians about potential harm and suffering and also encouraging family members to address these concerns directly with the physicians without trying to offend anyone involved. Bloomer, Endacott, O’Connor, and Cross (2013) found similar results in their study on understanding the nurse’s influence on end of life care, in that nurses demonstrated a clear preference for physicians to alter the focus of care from acute aggressive treatment to end of life care. The findings from my study point towards the subordinate role of nurses. The subsequent subtle power differences between doctors and nurses appear to be influencing patient care (Bloomer, Endacott, O’Connor, & Cross, 2013). These differences have historical origins which still appear to be influencing how nurses are approaching and working with physicians in regards to how they deal with critical issues such as end of life care.

The nurses from this study revealed a great deal of moral distress when they were forced to comply with Full Code treatment interventions, particularly when they were not able to effectively communicate with the family and physician about the potential harm. Nurses repeatedly highlighted the immense power that physicians held in regards to influencing and directing the end of life care of their patients. The nurses equated the end of life outlook of the physicians as determining factors on how far aggressive treatment was taken for dying patients. These findings remind us how physicians and nurses must work together as a cohesive team in discussing end of life preferences with the patient’s and family members. In addition, both
physicians and nurses may need be educated about their roles in end of life decision making specifically regarding DNR.

5.2.3 Context of Acute Care

Findings from this study revealed how the complex characteristics of the acute care environment influenced nursing care of DNR designated patients. In fact, nurses in my study attributed their moral distress to features of this complex care environment. One of these features identified by the nurses related to the lack of hospital beds in acute care. Nurses indicated that the impersonal and crowded environment of their acute care units was harmful and impeded their nursing care of dying patients. They found the subsequent lack of privacy to be unethical, frustrating and cruel for grieving family members. Nurses in other studies have also reported how the acute care environment is unfit for the care of the dying and is even undignified (Bloomer, Endacott, O'Connor, & Cross, 2013; Brereton, et al., 2012; McCourt, Power, James, & Glackin, 2013; Thompson, McClement, & Daeninck, 2006). In my study, it was evident that the culture, philosophy and organization of acute care made it difficult for some nurses to prioritize the needs of the dying within their workload. The nurses commented on how the chaotic and fast paced environment of acute care intensified the unmet needs of the dying patients and their family members. Similar to other studies, the nurses found it difficult to try to juggle care of the dying patient and active treatment patient (Bloomer, et al., 2013; Brereton, et al., 2012; McCourt, Power, & Glackin, 2013).

Overall, the findings of my study point to the reality that end of life care is constrained by resource availability, which means that patients often die in shared rooms. Such situations
occur irrespective of patient and family preferences or professional and ethical obligations to provide privacy. This raises questions about how nurses can advocate for their dying patients within this type of environment. How can nurses ensure a good death in acute care despite these environmental limitations? Another question that arose related to whether a clear unit philosophy on caring for dying patients would assist nurses to provide a better standard of within this environment.

Another aspect of acute care described by the nurses related to the lack of staff, and specifically the lack of support experienced when caring for dying patients. The findings from my study revealed that nurses felt alone in situations when trying to support older adults at the end of life and their families. Because they felt unsupported due to time constraints and lack of support from other colleagues, they were less able to give support to families of dying patients. These results concur with other studies (McCourt, Power, & Glackin, 2013; Thompson, McClement, & Daeninck, 2006). Findings from my study revealed that nurses feel overworked, overwhelmed with their own patient workload, and have little sense of control over their work environments. These challenges impeded them from communicating with their own colleagues regarding care interventions of dying patients or supporting family members of the dying patient. This resembles results from another study done by Tornquist, Andersoon, and Edberg (2013), where nursing care demands of dying patients required intensive collaboration within and between various care providers. Furthermore, without adequate support nurses feel uncertain about how to exercise their professional responsibility and decision making.

Further, the results of my study point to the importance of effective and visible leadership in acute care; leadership that must support nursing practice related to end of life care. Instead of
individual nurses working in isolation caring for their dying patients, a more team-centered approach could help nurses cope with the immense technical work and emotional pressures generated by caring for a mix of both active treatment and dying patients (Beckstrand & Kirchhoff, 2005). In addition, acknowledgement and appreciation from management and nursing educators about how hard it is (emotionally and physically) to juggle quality care for dying patients is essential in this type of environment. Nurses in my study all expressed that they strived to provide the best possible care. Nurses still felt a large degree of guilt and tension between the quality of care they knew they should be delivering and what they could actually deliver in practice. Some felt their efforts were never recognized. It is clear that nursing practice within this type of environment is influenced by larger contextual influences and constraints. Therefore, providing adequate nursing staff support is essential to foster high quality nursing care for older dying people. Nurse’s knowledge, skills and dedication must be acknowledged and supported in acute care particularly when they care for older adults who are dying.

5.2.4 Barriers and Facilitators to Ethical Practice Related to DNR

5.2.4.1 Barriers

This qualitative study provided insight into the care experiences of nurses caring for older adults with DNR designations in acute care. Related to my analysis, it is evident that there are specific barriers identified by nurses about their ethical practice related to dying DNR patients. Nurses viewed themselves as primary care givers for older adults in acute care and consequently their practice behaviors have significant implications for patient care and outcomes.
Nurses from this study identified conflicts in communication as a major barrier to their ethical practice related to DNR. This conflict in communication was with physicians, family members and other health care professionals and concurs with finding from other studies (Bloomer, Endacott, O’Connor, & Cross, 2013; Dunn, Otten, & Stephens, 2005; Jezewski, 1994; McCallum & McConigley, 2013; McCourt, Power, James, & Glackin, 2013). Specific ethical barriers related to inadequate pain management, physicians lack of availability, over or under treatment of patients and overall curative treatment perspectives. The findings from my study revealed that conflict arose when physicians and families focused on aggressive treatment despite an overall poor prognosis and invasive procedures against the wishes of the patient. Some nurses in this study often questioned the decisions of the family and physicians to continue life-sustaining treatments despite a poor quality of life but lacked the experience in age, practice or assertiveness to question the physician’s orders and family decisions. These findings also point to the need of enhanced communication between physicians, nurses and family members regarding the care of dying older adult patients.

Another interesting finding of my study related to how nurses worked in ways to avert such conflict through advocating, educating and mediating between physicians and patients and their family members. The data reveals that these types of relational interactions highly affect responses and experiences of these nurses. These findings concur with other studies (Jezewski, 1994; Jezewski, Miller, & Battista, 1993; Manias, 1998). According to Jezewski (1994), this type of nursing role is even more prominent when families are trying to decide whether to sign the DNR form. In my study, the nurses provided detailed descriptions of how some family members could not accept that their older adult family member was dying and wanted to continue invasive
treatment due to negative perceptions of DNR status. Nurses found this as morally distressing but often still respected the wishes of the family even though they found such instances as unethical. These findings point to need to the provision of better family support for their dying loved ones and increased educational effort in allaying family fears regarding DNR. For improved communication to occur a change in the acute care environment culture must occur in recognition that nurses are continually juggling end of life care and curative care.

Other barriers reported by nurses in this study related to their lack of experience and lack of education regarding end of life care. The findings in my study revealed that novice nurses lacked the experience and confidence to liaise more effectively with health care team and family when caring for dying older adults. Nurses spoke of the limited education they received in nursing school regarding death and felt they were not prepared for providing end of life care. Because of this lack of experience and education, they felt inadequate in being able to support family members with their dying loved ones. These results concur with previous studies (Gamma, Barbosa, & Vieira, 2012; Dunn, Otten, & Stephens, 2005; Thompson, McClement, & Daeninck, 2006; White & Coyne, 2011). Such gaps in knowledge about end of life care have implications for nursing practice. Education about the dying process and symptom management is essential so that safe and competent care can be practiced. The nurses in my study showed an overwhelming desire for more education about end of life processes. They also wanted to review their hospital-specific new advance directive form. It is critical that nurse educators and clinicians take advantage of this appeal for advanced education for end of life issues. Seizing this audience and opportunity can help propel positive end of life care practice.
5.2.4.2 *Facilitating Factors*

In addition to barriers to nursing practice, nurses in my study described factors that currently facilitate safe and ethical care of DNR designated patients. The most important facilitating factor that was reported by the nurses supporting their ethical practice in regards to DNR in my study related to collaboration amongst the family, patient and the health care team. Previous studies have found similar results (Beckstrand & Kirchhoff, 2005; Jezewski, 1994; Jezewski, Miller, & Battista, 1993; Manias, 1998). The nurses in my study stressed the importance of having the entire interdisciplinary team being involved and aware of the end of life care wishes of dying DNR designated. The nurses believed that having this understanding promoted consistency and efficiency in care, especially when patients care directions changed from active treatment to comfort modalities. In addition, these nurses emphasized that having this common understanding and collaboration also reduced the conflict, confusion, moral distress, and allowed everyone to be vigilant of the patient’s needs especially with end of life care. These findings correspond to Beckstrand, Callister, and Kirchhoff’s (2006) study on critical care nurses suggestions on for improving end of life care. Nurses in their study reported that communication was essential in facilitating a good death as the entire interdisciplinary team could work toward the same goal of care.

Findings from my study indicated that this increased team collaboration efforts would promote earlier cessation of active treatment, and patient suffering entailed through aggressive treatment. These findings suggest the need to improve communication amongst the interdisciplinary team, perhaps through the use of confidential communication technologies or tools. These tools can prevent some of the conflict that occurs when patients are no longer able to
participate in end of life decision making (Beckstrand, Callister, & Kirchhoff, 2006). One nurse from my study suggested having a designated nurse specialist who liaises with the health care team, patient and family regarding end life preference so that care goals can be maintained in a compassionate manner.

Other facilitating factors for ethical practice of DNR designated patients that were identified in my study related to education. Education was viewed as essential in improving care practices and assessment skills for dying DNR designated patients. Education was seen as crucial for practice improvements, advocacy and support for family members. These findings were comparable to other studies in the literature related to nursing practice and end of life care (Beckstrand, Callister, & Kirchhoff, 2006; Thompson, McClement, & Daeninck, 2006; White & Coyne, 2011). Team work and support were also associated with fostering better nursing care and practice through delegation, shared decision making and focus on positive team values. These findings coincide with the current literature (Beckstrand, Callister, & Kirchhoff, 2006; McCallum & McConigley, 2013; Törnquist, Andersson, & Edberg, 2013). The final factor that was identified as facilitating safe and ethical nursing practice was higher nurse to patient ratio. This was believed to increase staff cohesion, advocacy and education. The findings of my study emphasis the ongoing need to foster these positive practice factors for nurses caring for DNR designated patients in acute care. The data from my study clearly points to the critical nature of these facilitating practice factors for promoting quality end of life care, toward a dignified death.
5.3 Nursing Implications

My intent for this research study was to contribute to the foundational knowledge of the nursing care nursing care of older adults with DNR designations on medical/surgical units in acute care. Although, this was a small qualitative study, I believe a greater understanding of medical/surgical nurses care experiences is necessary to inform education, practice and policy.

5.3.1 Nursing Education

Understanding the care that medical/surgical nurses provide for their older adult patients with a DNR status is crucial for nursing education. Despite the issue having been identified several times in the past decades, the incorrect interpretation of DNR designations still occurs by nursing staff. This lack of understanding in meaning as well as care practices associated with DNR designations is a cause for concern, as it has physical consequences for patients but it also has ethical and moral implications for patient care. The general ambiguity surrounding the term combined with the reality that older adults are more likely to receive these orders indicates the significance of educating nurses about DNR ranging from the undergraduate level, from novice nurses to advanced practice nurses.

Critically examining nursing care practices provides opportunities for nurse educators as well as nursing educational programs to evolve to meet the challenges associated with caring for older adults with a DNR status in acute care. In addition, understanding experiences will highlight the complexity of practice constraints to educators which may provide impetus for further nursing training, information workshops and formal education surrounding DNR, which ultimately will ensure that nurses are better prepared to care for their patients and families that
are in this situation. This also promotes insight and appreciation for this critical health care decision which can ultimately aids achievement of patient care goals as well as family support.

5.3.2 Nursing Practice

With this research project, understanding nursing care of older adults with a DNR designation will add further insight into their contexts of practice which can serve important social functions. As these experiences will be rooted in interactional and organizational contexts, they can provide a strong moral force which will allow the critical examination of acute care nurses practice constraints and ethical dilemmas in caring for DNR designated older adults. As nursing practice in relation to DNR can have permanent consequences on the health outcomes of patients, it is essential to acknowledge and recognize the associated issues and problems associated with caring for older adults with DNR orders. These practice constraints and associated complexities can be brought to the forefront of nurse educators, policy makers and key stakeholder’s in the organization so that best practice can be supported.

5.3.3 Nursing Policy

As indicated in the literature and in my study, it is clear that nurses have limited participation in the DNR decision for their patients and are largely confused of the details of the DNR policies specific to their institution. However, interpreting and describing acute care nurses’ care practices can highlights the reasons behind this lack of involvement in policy making and understanding of organization specific DNR polices. Since nurses are left with the repercussions of caring for DNR designated patients, it is essential to educate nurses about the importance of becoming involved in DNR decisions and policy making so that they can
effectively advocate for the patient wishes while upholding their legal mandate. In addition, involvement in policy making is crucial for the progression of the nursing profession in order to address specific care concerns related to end of life care. Essentially, without nursing involvement and awareness of DNR policies and practice guidelines quality care cannot be implemented.

5.4 Recommendations for Further Research

Because this is the one of the first studies conducted of the understanding of acute care nurses in British Columbia in relation to their nursing care of older adult patients with a DNR further research is needed on this topic. The misinterpretation and misapplication of DNR still persists today despite decades of research on this topic. Further research is required on how to better educate nursing staff starting from undergraduate program to advance practice education sessions regarding end of life care. In this way, research is required on assessing the impact of education programmes on health care professionals understanding of DNR. The findings of this study clearly showed the limited participation of nurses in the decision making process, therefore future research on developing a nursing role in resuscitation decision making process is required.

5.5 Chapter Summary and Conclusion

In this chapter, I examined the findings in relation to the existing literature. I presented nursing implications generated from the discussion and made recommendations for nursing practice, education, policy and research. The implications addressed the importance of formulating new approaches to deal with the nursing barriers to practice associated with DNR. Specifically, larger efforts are required to maintain the clarity of instruction in acute care in
relation to DNR orders. In addition, nursing leaders need to address the underlying assumptions and stigma associated with DNR. In order to tackle these negative end of life beliefs, nurse leaders must support nursing practice related to end of life care and foster team centered approaches to facilitate nurses caring for a mix of both active treatment and dying patients.

Given the chaotic environment of acute care, the problems of miscommunication surrounding DNR orders are intensified. Therefore, discourse related to end of life care with the interdisciplinary health team, patients and families should occur early on during the hospitalization process. The results of this study suggest that emphasis should be placed on improving physician-nurse interactions in the DNR decision making process. It also suggests that nurse involvement in this decision-making process should be encouraged on acute care wards. Research can explore how nurses working in acute care can be further involved in DNR decision-making. In addition, research is required to assess the impact of education programmes on health care professionals understanding of DNR. To this end, I plan to communicate the results of this study by seeking publication in a peer-reviewed journal, through presentations to the units where recruitment occurred, and by presenting a summary of findings to Evaluation and Research Committee of the Health Authority involved in the research.

In conclusion, this study was one of the first to explore understanding of the nursing care of older adults with DNR designations on medical/surgical units in acute care. The complex characteristics of the acute care environment influenced nursing care of DNR designated patients older adults in this study. Nurses working on these units are interested in participating DNR decision-making and should be provided the opportunity to do so. The findings of this suggest that DNR orders are incorrectly interpreted by nursing staff despite the hospital’s new policy.
Further research should investigate the impact of educational programmes regarding DNR on nurses’ understanding of DNR and practice delivery. Perhaps, increasing nurses’ accountability for making end of life improvements is necessary to avoid the ongoing over-interpretation of DNR orders. It is hoped that this research will convey important insights and meaningful connections that will help keep the issue of misinterpretation and misapplication of DNR and the ethical issues relating to the care of older adults in acute care in the forefront and assist in shaping future best practice standards.
References


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Appendices

Appendix A  Participant Informed Consent Document

PARTICIPANT INFORMED CONSENT

Understanding Nursing Care of Older Adults with “Do Not Resuscitate” Orders on Acute Medical/Surgical Units

Principle Investigator  
Navjot Saran, RN, BSN  
University of British Columbia-Masters of Science in Nursing

Co-Investigator  
Jennifer Baumberg, RN, PhD  
Associate Professor, UBC School of Nursing

INTRODUCTION

The purpose of this study is to explore nursing experiences of caring for older adults with “Do Not Resuscitate” orders in acute care. You are being invited to participate in this research study because you are a Registered Nurse who is currently working on a medical or surgical unit for more than 6 months and have been working greater than or equal to 0.5 full time equivalent (FTE) at the study site.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary. Before you decide whether you would like to participate, it is important for you to understand what the research involves. If you do decide to take part in this study, you can still withdraw at any time and without giving any reasons for your decision and without jeopardy to your employment. If you do not wish to participate, you do not have to provide any reason for your decision.

WHO IS CONDUCTING THIS STUDY?

This study is part of Navjot Saran’s Masters Degree in Nursing at the University of British Columbia. Direct quotes may be published in a thesis or in oral or written publications but your name will not be linked to these quotes. No identifying information will be present in the published results.

BACKGROUND

In recent years, the use of DNR orders in acute care has been increasing, especially for older adults. Unfortunately, many nurses misinterpret the definition of DNR and this knowledge gap has implications for how care is provided for older adults. So, we would like to invite you to...
participate in our study and to share about your experiences, feelings, challenges, and examples of nursing care when taking care of older adults with a DNR status.

WHAT IS THE PURPOSE OF THIS STUDY?

The aim of this project is to understand nursing care of older adults with a DNR status on acute medical/surgical units.

WHO MAY PARTICIPATE?

Registered nurses who are currently working on a medical/surgical unit for more than 6 months and have been working greater than or equal to 0.5 full time equivalent (FTE) at the study site are invited to participate in this research study.

WHAT DOES THE STUDY INVOLVE?

Participants will take part in a face to face interview that will take between 60 to 90 minutes. The setting of the interview will occur at a mutually convenient location. Settings may range from the hospital, informal meeting rooms, coffee shop or the participants home. In some cases, a second interview may be needed for clarification or to gather more information. Interview(s) will be audio-taped to ensure the accuracy of the conversation, and confidentiality will be maintained at all times. All names if used will be removed during the transcription to ensure confidentiality. In addition, basic demographic information, including information regarding ethnicity, will be collected. Participants will be notified that the provision of this information is voluntary and will only be used to provide the context for describing the study sample. This information will not be linked to individual participant’s responses and will be used only for the purposes of describing the sample as a group. The questionnaire will take about ten minutes to complete at the outset of the study.

WHAT ARE THE POTENTIAL BENEFITS AND RISKS OF THE STUDY?

There are not direct benefits from participating in the study. This study involves minimal risk to participants and is unlikely to adversely affect the rights and welfare of participants. During the interview, you will be asked to describe your memories/stories/experiences about taking care of DNR designated older adults; therefore, some psychological impact (i.e., sadness, negative emotions/discomfort, etc.) can be encountered during and after the interview. To manage this possibility, information about counseling services that are available at your workplace can be provided. The following resources are available to you at no cost to you: Employee and Family Assistance Program (EPAP). EFAP is a non-profit confidential counseling program specialized to provide service to healthcare employee and families throughout BC. Toll free number: 1-800-505-4929 or www.efap.ca/.

WHAT WILL THE STUDY COST ME?

Participation in this study will not result in any expense to you. As a token of appreciation for your time, you will receive $25 coffee gift card.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Consent Form Version 2 February 16, 2013
We respect your privacy and maintain confidentiality. The information that we gather from this research project will be kept private. The information from this study will be kept in a secure, locked location. Only members of the research team (the researcher and committee members) will be able to look at the information. It will not be shared with or given to anyone except the research team. Any information about you will have a number on it instead of your name. Your name or identifying information will not be published in any reports. We will keep a copy of this research consent form and also give you a copy for your records. After each interview, the digitally recorded data will be password-protected and stored on the server at UBC to maintain confidentiality. All documents will be identified only by a code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports for the completed study. No data will be stored or downloaded onto unsecured computers or on the Web.

CONTACT INFORMATION FOR THE STUDY

If you have any questions or desire further information with respect to this study, you may contact Navjot Saran at (778) [redacted] or Dr. Jennifer Baumbusch at (604)- [redacted]

CONTACT FOR CONCERNS ABOUT THE RIGHTS OF PARTICIPANTS

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject information Line at the UBC Office of Research Services at 604-822-8598 or send email to RSOL@ors.ubc.ca. You can also contact Dr. Anton Granfeldt and/or Dr. Allan Belzberg, Research Ethics Board [REB] co-Chairs by calling 604- [redacted] at Fraser Health.

YOUR RIGHTS AND CONSENT

Your participation in this study is entirely voluntary and you may refuse to participate or may withdraw from the study at any time without jeopardy to your employment. If you withdraw from the study, any data that you provided will be removed prior to the analysis. Your signature below indicates that you have received a copy of this consent form for your own records. Your signature also indicates that you consent to participate in this study. By signing this form, you do not give up your legal rights.

Consent Form Version 2 February 16, 2013

FHREB APPROVED: 2013 February 19
SUBJECT CONSENT TO PARTICIPATE

Understanding Nursing Care of Older Adults with ‘Do Not Resuscitate’ Orders on Acute Medical/Surgical Units

By signing this form, I agree that:

1) The study has been explained to me and all of my questions have been answered
2) The possible harms and benefits (if any) of this study have been explained to me.
3) I am free now, and in the future, to ask questions about the study.
4) I understand that no information about who I am will be given to anyone or be published without first asking my permission.
5) I have read and understood this consent form.
6) I consent to take part in this study.

Printed Name of Participant Signature & date

Printed Name of Researcher Signature & Date

Consent Form Version 2 February 16, 2013

FHREA APPROVED: 2013 February 19
LETTER OF INITIAL CONTACT

Understanding Nursing Care of Older Adults with ‘Do Not Resuscitate’ Orders on Acute Medical/Surgical Units

Principle Investigator
Navjot Saran, RN, BSN
University of British Columbia-Masters of Science in Nursing
(778) 835-5150

Co-Investigator
Jennifer Baumbusch, RN, PhD
Associate Professor, UBC School of Nursing
(604) 822-7496

Thank you very much for your interest in this study.

The aim of our study is to understand the nursing care of older adults with a DNR status on acute medical/surgical units. Data collection for the study will occur through a semi-structured interview conducted by a Master’s of Science in Nursing graduate student who is conducting this research as part of a master’s thesis.

The registered nurses who are willing to participate will be asked a series of questions designed to capture their experiences of their nursing care of older adults with a DNR status. The interview will approximately be 60 to 90 minutes at length and will be conducted at a mutually convenient location and time.
A small honorarium of $25.00 (coffee gift card) will also be offered to all participants for their time and input.

The interviews will be audio-taped. Tapes will be transcribed into computer files, and then stored in a locked file cabinet. All tapes will be kept for five years and then destroyed. Participants will be encouraged not to use names during the interview and if names are used they will be removed during transcription. Participants will not be identified by name in any reports of the completed study. All participants will be requested to keep interview discussions confidential.

A potential risk associated with your participation in the study is that you may feel uncomfortable discussing your experiences with caring for older adults with a DNR status. Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment.

If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, please contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca You can also contact Dr. Anton Grunfeld and/or Dr. Allan Belzberg, Research Ethics Board [REB] co-Chairs by calling 604-587-4681 at Fraser Health.

Thank you for your interest. If you have any questions regarding the study please contact Navjot Saran (778) 835-5150.
Appendix C  Research Study Email and Flyer Advertisement

Research Study Email and Flyer Advertisement

Understanding Nursing Care of Older Adults with ‘Do Not Resuscitate’ Orders on Acute Medical/Surgical Units

Purpose of this study:
This research study is part of a thesis (public document) for a Master of Science in Nursing (MSN) Graduate degree from the University of British Columbia to understand the nursing care of older adults with a DNR status on acute medical/surgical units. In recent years, the use of DNR orders in acute care has been increasing, especially for older adults. Unfortunately, many nurses misinterpret the definition of DNR and this knowledge gap has implications for how care is provided for older adults. So, we would like to invite you to participate in our study and to share about your experiences, feelings, challenges, and examples of nursing care when taking care of older adults with a DNR status.

Who can participate?
- Acute Medical/Surgical Nurses who have cared for older adults with a DNR status
- Have worked for more than 6 months
- Working more than 0.5FTE

What is involved?
You will be asked to share your experiences in taking care of older adults with a DNR status, how you define DNR and what do you see as barriers or facilitators to your ethical practice related to DNR orders. The place and time of the interview will be arranged with you by the researcher as convenient to you. The interview will be audio-taped and will no longer than 90 minutes. Interview and discussion will keep strictly confidential and will only be used for this research study. In addition, basic demographic information will be collected for the purposes of describing the sample as a group. The provision of this information will be voluntary and will not be linked to individual participant’s responses. Each participant will also receive an honorarium in the amount of CDN$ 25, as a coffee gift card at the end of the interview.

When does this study take place?
The study will take place from February 2013 to May 2013.

Principle Investigator
Navjot Saran, RN, BSN
University of British Columbia-Masters of Science in Nursing
Co-Investigator

Jennifer Baumbusch, RN, PhD
Associate Professor, UBC School of Nursing
(604) [Redacted]

If you are interested in participating in this study, or have any questions with respect to this study, please feel free to contact us. Thank you!
Appendix D  Participant Demographic Questionnaire

Participant Demographic Information

Understanding Nursing Care of Older Adults with ‘Do Not Resuscitate’ Orders on Acute Medical/Surgical Units

Please fill out the following questions. This information will not be linked to individual participant’s responses and will be used only for the purposes of describing the sample as a group. Providing this information is voluntary.

Participant Identification Number (as assigned during the interview e.g., P1, P2) _______

1. Age: ________

2. Sex: Male ________ Female ________

3. Ethnicity __________________________

4. Highest Level of Nursing Education:
   Diploma ________
   Undergraduate Degree ________
   Post Graduate Specialty Certification ________
   Masters ________

5. Length of Nursing Experience (years) ________

6. Length of Experience as a Medical or Surgical Nurse(ys) ________

Fraser Health Ethics Board Version 2 February 16, 2013
Appendix E  Semi-Structured Interview Guide

Medical/Surgical nurses Caring for DNR designated Older Adults

Researcher
A. Thank the participants for taking part
   1. Introduce yourself and provide some background
B. Objective of the study
   1. Why the research is being conducted
   2. What are the goals of the research
C. Explanations
   1. Length of time of interviews
   2. Confidentiality of participants: The discussions that occur while interviewing are confidential. Participant names and any other identifying information will be removed from the data during the transcription process.
   3. Participants can terminate the interview at any time
   4. There is no right or wrong narrative, participants are free to speak about their experiences
   5. Any questions or comments

D. Interview Questions

1. We’ll start with something very straightforward: Tell me in your own words – what is a DNR designation? What does that mean? (RQ1)

2. What has been your experience as a nurse working with older patients with DNR designations? (RQ2,3,4)

3. Is there a particular experience that stands out in your mind (either one that you felt was very positive, or one that did not go well). Can you tell me what happened – all the details as you can best recall? (RQ2,3,4)

   Prompt for a contrasting story, e.g. That sounds like it was a very difficult experience for everyone. Have you had a time when things went quite differently – where you felt things went well for example?

4. Does having a DNR designation influence the way nurses provide care for older adults?

   Probe for further depth and detail; Prompt for context if not spontaneously mentioned, e.g. is it different when the patient is younger? does a DNR order influence how nurses care for older adults at the end of life? (RQ2,4)

5. What helps nurses provide good care to older adults with a DNR designation?

   If necessary prompt with “safe and ethical” (RQ3, 4)
6. What gets in the way of nurses providing good care to older adults with a DNR designation? What are the barriers?

*If necessary prompt with “safe and ethical” (RQ3,4)*

7. Is there anything else you'd like to mention - something we have not yet discussed?

E. Conclusion
   1. Thank you for participating
   2. Collect demographic information on participants
   3. Provide contact information