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Fall 12-20-2020

Perioperative Advanced Directives

Derek Washer

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Recommended Citation

Washer, Derek, "Perioperative Advanced Directives" (2020). *Doctor of Nursing Practice Projects*. 133.
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Perioperative Advanced Directives

Executive Summary

Problem Introduction

As technology and surgical techniques improve, more clients with advanced directives are presenting to the operative suite for surgery or procedures requiring anesthesia. Anesthesia providers at a North Texas hospital are in a critical position to discuss with clients and their surrogates, any reconsiderations, or alterations made to the client's directives perioperatively.

At the 237-bed hospital in Texas, discussions were limited due to a hospital policy automatically rescinding all advanced directives during anesthesia care. The anesthesia providers at the facility expressed resistance to preoperative patient communication due to a lack of awareness, an outdated hospital policy, and no available consent specific to advanced directives under anesthesia. The hospital policy rescinded all advanced directives upon a patient's arrival to the operative suite. Staff education and updating hospital policy and consenting mechanisms to national standards increased awareness of operating room nursing staff. It also reduced resistance by the anesthesia providers responsible for preoperative anesthesia consenting.

Literature Review

A consensus exists among professional organizations directly involving the perioperative care of patients with advanced directives. Position statements by the American College of Surgeons (ACS, 2014), the American Society of Anesthesiologists (ASA, 2018), and the Association of periOperative Registered Nurses (AORN, 2014) all agree the clinical practice guideline and standard of care is a "required reconsideration" of advanced directives.

In preserving provider ethics and patient autonomy, patients must always retain the right to decide on their medical care, after being adequately educated by their provider. The automatic rescinding of advanced directives in the perioperative arena is morally wrong and ethically

unfounded (Hardin & Forshier, 2019; Jackson, 2015). Nurses, including Advanced Practice Nurses (APNs), have an ethical obligation to educate and advocate for a patient's legal right to self-determination (Miller, 2017).

The rescinding of advanced directives was common practice during the 1980s. The morals and ethics of such training were later questioned with the passing of the Patient Self-Determination Act (PSDA) in 1990. The PSDA encouraged patients to make decisions on the extent and types of medical care they would refuse or accept should they become unable to make decisions (Miller, 2017). Despite the PSDA in 1990 and the much later practice recommendations put forth by professional organizations, the practice of rescinding advanced directives perioperatively continues in some facilities. In a physician survey by Hadler, Newman, Raper, & Fleisher (2016), only 34.8% of physicians report confirming any advanced directive before taking a patient to surgery. In the same study, over 90% of the physicians surveyed thought critically ill patients undergo surgery without adequate discussion of the impact on their post-surgical quality of life (Hadler, Newman, Raper, & Fleisher, 2016).

The ethical considerations surrounding perioperative advanced directives hinge on an adequate discussion between patient and provider and the importance of documentation of any modifications or exceptions to the directives (Sullivan, 2015; Sumrall, Mahanna, Sabharwal, & Marshall, 2016). Suspension of advanced directives, a continuation of directives, or an alteration of the directive is ultimately a patient's right of choice.

In one study, ninety-two percent of patients surveyed believed a provider and patient discussion should occur, and fifty-seven percent of patients agreed to a suspension of advanced directives perioperatively (Burkle, Swetz, Armstrong, & Keegan, 2013). For a patient to make an informed decision, anesthesia providers and surgeons must be willing to have adequate

preoperative discussions with patients. Kalkman, Hooft, Meijerman, Knape, & van Delden (2016) state, “Preoperatively communicating the evidence to patients allows for better-informed decisions and less moral distress on anesthesia providers.”

The risk of legal liability is negligible when preoperative discussion regarding the patient's advanced directive is executed, documented, and communicated to stakeholders and is based on the patient's wishes (Hardin & Forshier, 2019; Pope, 2017). Any policy automatically rescinding advanced directives do not support a patient's legal right to self-determination and autonomy (Byrne, Mulcahy, Torres, & Catlin, 2014; Sullivan, 2015).

A patient's rights do not end when they enter the perioperative arena and consent to surgery and anesthesia. No single piece of literature reviewed supports the automatic rescinding of patient's advanced directives perioperatively. The research strongly argues that any such policy is unethical and could end in legal implications. Legal liability is less when adequate discussions occur and are documented, demonstrating a patient's wishes. All policies regarding perioperative advanced directives must be updated to current standards. Anesthesia provider awareness in handling patients who present with established advanced directives is crucial to securing a patient's right to autonomy and self-determination.

Project Methods

The perioperative advanced directives project was a non-experimental, non-research descriptive design used to update hospital policy and create an evidence-based consenting mechanism for patients presenting perioperatively with advanced directives. The policy and consenting tool served as a guide for anesthesia providers in maintaining a patient's right to autonomy and self-determination. A pre and post-educational survey evaluated anesthesia provider and nursing staff concerns, knowledge, and understanding of perioperative advanced

directives. The goal was to educate all involved, therefore alleviating concerns and reducing resistance to perioperative discussions with patients presenting with advanced directives. The project did not involve the collection of patient information or any interaction with patients.

Project Sequence. Using the current literature, the initial phase of the perioperative advanced directives project involved communicating with the facility's quality department and top-tiered administration the crucial need for an updated policy. Simultaneously, while working with the quality department and facility administration to update the policy, anesthesia providers and perioperative nursing staff completed a pre-educational survey.

Once the new policy and consenting mechanism were destined for approval, and after pre-surveys were completed, educational activities took place. The project consisted of educating nursing staff and anesthesia providers using a PowerPoint presentation. The presentation was also provided to several other nursing units outside of the perioperative setting, bringing additional awareness and prevention of misinformation related to the new policy. The additional presentations to nonoperative staff were not included in the pre and post-survey data collections.

Over another week, individual one-on-one sessions were provided to each of the six anesthesia providers. The individual anesthesia provider sessions were deemed necessary to assure the providers were comfortable and confident with the new policy and utilizing the "DNR Under Anesthesia" consenting form.

After the new policy was in place for one month, allowing staff to work with the new form and ask questions, a post-survey was provided. The post-survey included the same four true or false and six Likert questions. Post-survey respondents included the same anesthesia providers and perioperative nursing staff who completed the pre-survey one month prior.

Setting. The project's location was a Level 3 Trauma Center with over 230 inpatient beds in Sherman, Texas. The surgery department consists of approximately twenty Registered Nurses (RNs) who function in different roles, such as circulating the operating suites, surgical scrubs, preoperative holding, and post-surgical recovery areas. Eight independent anesthesia providers provide general, regional, and sedation anesthesia to patients across the lifespan.

Institutional Review Board. As a quality improvement project, the perioperative advanced directives project received exempt status from the IRB of Southern Illinois University Edwardsville (SIUE) on June 9, 2020. The project is not intended as a research study and does not collect any patient information. The policy update and consenting mechanism component of the project were handled at the facility committee level. The pre and post educational surveys were conducted voluntarily. Individual subjects completing the surveys remained anonymous, and only the statistical analysis was reported. All necessary approvals from WNJ and SIUE were obtained before survey distributions and educational presentations.

Evaluation

Survey. The survey consisted of four true or false questions addressing anesthesia and nursing staff familiarity with ASA and ACS guidelines on advance directives in the perioperative setting. The survey also included six Likert scale questions, surveying staff attitudes regarding advanced directives. Pre and post-survey responses underwent descriptive statistical analysis.

Outcomes. One hundred percent of post-survey participants correctly identified DNR orders should not be routinely suspended perioperatively, representing a 71% improvement from the pre-survey. Interestingly, all nursing staff and five out of six anesthesia providers (83%) correctly understood that it is not acceptable to automatically cancel DNR orders. This data represents a 73% improvement for nursing staff and a 50% improvement for anesthesia

providers. All nursing staff and anesthesia providers correctly realized how the administration of anesthesia could be viewed as resuscitation in other settings, representing a 12% improvement from pre-survey data. Success with educational activities also showed post-survey progress. All survey participants (100%) correctly acknowledged a patient's right to allow the surgical team, based on the patient's goals and values, to use clinical judgment in determining appropriate resuscitative measures.

Using descriptive statistics, the Likert question portion of the post-survey demonstrates improvement in comfort and confidence when patients present to the perioperative arena with advanced directives. Survey respondents were asked to rank their responses from one to five on six different Likert questions. The mean, mode, median, and standard deviations for each were determined for each item. The averages from the pre-survey were then compared to the post-survey responses, creating a "percent change" for the anesthesia provider group, the nursing staff group, and the two groups as a whole. The percent change in all questions represents improved confidence and comfort.

The anesthesia provider responses demonstrated a 100% and 107% improvement, respectively, in areas of understanding advanced directives and their comfort levels with discussing advanced directives with clients. Compared to beginning the advanced directives project, anesthesia providers demonstrated a 93% improvement in reviewing advanced directives routinely. The smallest gain for the anesthesia providers was the usefulness of advanced directives in decision-making with 17%.

Average nursing staff responses demonstrated similar improvement in confidence and comfort when compared to their pre-survey responses. Descriptive statistics show the most significant developments in reviewing a patient's advanced directive (52%) and understanding

an advanced directive (47%). Both Likert questions related to “comfort” levels demonstrated greater than 30% improvements from pre to post-survey results. A 17% improvement was noted in the following of advanced directives when making patient care decisions and a 14% improvement in the usefulness of advanced directives in decision making.

Impact to Practice

Data from the project suggests improved awareness and utilization of advanced directives in the perioperative arena by nursing staff and anesthesia providers. As a result of the facility policy update and project's educational components, anesthesia providers are prepared to adequately discuss options available for reconsidering a patient's advanced directives perioperatively. With the availability of the "DNR Under Anesthesia" consenting mechanism, anesthesia providers and nursing staff can adhere to national practice guidelines of a "required reconsideration." Policy adherence and utilization of the new consenting mechanism provides improved patient autonomy and self-determination, while also providing a legal safeguard for providers. The advanced directives project has high replicability. The presence of hospital policy and a required yearly educational module provides a high degree of practice sustainability.

Conclusion

The results of the perioperative advanced directives projects identified the need for an updated hospital policy and supportive educational mentoring to create comfort and confidence in both anesthesia providers and nurses. The project proved successful, as evidenced by the improved average responses from pre to post-survey data in each category. With the perioperative project's success, yearly education is now included in the computer modules required of all perioperative staff and thus promotes sustainability. Most importantly, the patients will now retain their rights to autonomy and self-determination in the perioperative arena.

Author Contact Information

Derek Washer, DNP(c), MSNA, CRNA, APRN

Sherman, Texas

(903) 870-8333

derekwasher@yahoo.com