**Do Not Resuscitate (DNR) – Honoring Patient Wishes**

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**Problem:** Unnecessary treatment of a DNR patient upset both the patient and family, and compromised the organization in supporting patient safety and dignity.

**What Should Be Happening:** No patient who chooses to be DNR should be resuscitated. DNR wristbands should be applied on the patient within 4 hours of physician order 100% of the time.

**What is Actually Happening:** 1-2 times a year, a DNR patient is wrongly resuscitated or experiences some form of life sustaining measure. DNR wristbands are being placed 33% of the time in critical care units and 56% of the time in medical surgical units.

**Root Cause:** Failure to adhere to the policy standard to place the wristband within 4-hours or order.

**Hypothesis:** If we design a method to assure the DNR wristband has been placed per MD order, we will never have a DNR patient resuscitated unnecessarily.

**Countermeasures:** The first 5 countermeasures failed forward. Countermeasure #6 closed the gap.

**#1 Epic Flowsheet row:** to capture documentation of the band placement.

**#2 Best practice alert (BPA):** fires at 4-hours post DNR order if documentation missing; continues to fire every time the chart is opened until documentation is verified.

**#3 Epic workbench report** pushed to the unit charge nurses at 4pm and 4am.

**#4 Data Reports:** A red/green weekly report (hoping to instill a sense of competition) sent to unit managers weekly.

**#5 Standard Work:** to assure RNs and Charge nurses adhered to the countermeasures.

**#6 The Joint Commission Tracer Audit:** done monthly in each unit. This audit requires a visual assessment of the patient to assure the DNR wristband is placed on the patient’s wrist.

**Outcome Results:** 99% adherence with DNR orders since implementation of countermeasure #6.

**As a result of this NEW countermeasure, countermeasures 2, 3, 4 and 5 have been eliminated, reducing waste in the process.**

**Key Learnings:**
- It takes many plan-do-check-adjust (PDCA) cycles to close and sustain a gap.
- Failing forward does not close the gap but does contribute to learning.
- Following your data over time is crucial.

**Success Factors:**
- Collaboration of teams: Nursing Case Peer Review, Patient Safety, Practice Council, Patient Advocacy, Clinical Excellence, IS/Epic staff, BI staff, management staff, accreditation.
- Nursing Case Peer Review Committee making this problem solving for patient safety a priority for the organization and allocating adequate resources.

**Next steps:** Sharing the success with a Magnet Exemplar.

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