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Healthcare Provider's Experience in caring for patients with Do-Not-Resuscitate Orders: A Qualitative Study

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Not all do-not-resuscitate (DNR) patients receive appropriate care from healthcare professionals. Furthermore, several studies have revealed that workload and a lack of specialized knowledge for end-of-life care, in addition to other factors, all resulted in abandoned care for DNR patients. However, few studies have existed regarding healthcare providers' end-of-life care experiences for DNR patients. To explore healthcare providers' experience in caring for patients with Do-Not-Resuscitate orders at one ministry of health hospital, a descriptive qualitative study was conducted by reviewing the DNR policy and using semi-structured individual interviews with nurses and consultants (n=21) working in intensive care units and medical wards in this ministry of health hospital in Jeddah City. Thematic analysis was used to analyze the interview data. The current study demonstrated that there are few differences in nurses' experiences between intensive care and medical units, and that there is a difference in nursing care provided for DNR patients. Furthermore, nurses working in both units can only provide psychological support to patients' families regarding DNR decisions, while consultants experience a challenge in informing DNR decisions to patients' relatives. Clear nurse roles should be stated in the DNR policies to allow nurses to provide adequate care to DNR patients and their families. Furthermore, providing a more detailed explanation about DNR orders to patients' relatives would increase their awareness level.

Keywords: DNR patients, healthcare providers, different care, awareness level.

INTRODUCTION

"Do not resuscitate" (DNR) is defined as an order to intentionally not perform cardiopulmonary resuscitation (CPR) when a patient stops breathing or their heart stops beating (Nankundwa and Brysiewicz, 2017). A DNR order is issued when resuscitation would not lead to a better quality of life for the patient. Not all patients require Cardiopulmonary Resuscitation (CPR) and intubation after experiencing cardiopulmonary arrest; nonetheless, patients with terminal illnesses prefer a natural and peaceful death (Robinson et al. 2012). A DNR order is issued when it has been previously requested by the patient or their family, when the specialist concludes that resuscitation would be useless for the patient, or when CPR would restart a patient's heart but lead to a low quality of life (Millar, 2020). DNR is considered one of the most difficult decisions that physicians, patients, and caregivers have to make, and it can be influenced by physiological, demographic, and sociologic factors (Ouyang et al. 2020).

Several studies have been conducted on DNR

patients, but only two studies in the literature have explored the lived experiences of healthcare professionals caring for DNR patients. One of these, set in South Africa, was based on semi-structured interviews with six nurses to investigate their lived experiences caring for a DNR patient in an intensive care unit (ICU). The study revealed that the nurses considered DNR orders to be permissions to terminate the patient's life and, therefore, allow death to occur. Additionally, the nurses reported that DNR patients were given less priority by nurses in terms of providing care, as such patients do not usually require daily nursing care (Nankundwa and Brysiewicz, 2017). Another study exploring nurses' lived experiences in end-of-life care with a focus on DNR decisions was conducted in Saudi Arabia among twenty-six registered nurses. The study revealed that the provision of nursing care for end-of-life patients with a DNR request focused on making the patients comfortable instead of treating the disease itself or making medical diagnoses (Abu-Ghori et al. 2016).

Two additional studies found in the nursing literature have focused on nurses' roles with patients under DNR orders. In South Korea, a descriptive study conducted

among 252 ICU nurses aimed to assess their perceptions and attitudes toward DNR orders as well as to highlight the changes in nursing care after receiving the order. The results suggested that ICU nurses did not change their provision of nursing care if a patient had a DNR order (Park et al. 2011). Another study conducted in the Netherlands used VENICE's questionnaire in semi-structured interviews to explore the role of ICU nurses in end-of-life care (Noome et al. 2016). The analysis showed that nurses play a key role in implementing the care plan, including helping families understand the situation and prognosis of the patient. Additionally, ICU nurses have the skills and knowledge to address family members' concerns, answer their questions, and provide all the support that they require. The nurses' key role, however, is to try to relieve the patient of any physical discomfort and pain and provide them with emotional support, including allowing the family to visit at any time (Noome et al. 2016).

A recent cross-sectional descriptive study was conducted among 115 nurses in South Korea to explore burnout, job stress, depression, and job satisfaction among ICU nurses caring for DNR patients. The study demonstrated higher levels of burnout and depression among ICU nurses caring for DNR patients than among nurses caring for patients in general care wards. Moreover, this study indicated that job stress experienced by ICU nurses was related to the severity of the patients' illness (Sok et al. 2020). A descriptive-analytical study conducted in Iran revealed a similar result among 255 nurses investigating their attitudes in ICUs toward DNR orders. The analysis revealed that most nurses did not have a positive attitude toward DNR orders but agreed that they protected patients from suffering and that they were needed to safeguard patients' dignity. The study also showed that nurses with more than 15 years of experience had a more positive attitude than those with less experience (Naghshbandi et al. 2019). In Taiwan, a retrospective cohort study was conducted among 274 patients to study the characteristics and outcomes of critical illness in patients with previous DNR orders who were admitted to the emergency department at the hospital. The study found that 50% of these patients survived and were discharged, indicating that aggressive care was ineffective (Wang et al. 2019).

Several studies have discussed healthcare approaches to DNR decisions. A quantitative study in the US interviewed eighty-three nurses in 2020 to determine the relationship between the timing of DNR orders in the ICU and nurses' perceptions of patients' distress and quality of death. Analysis of the data demonstrated that patients with early DNR orders had the worst deaths. In addition, a study suggested that DNR patients would be better served if they were administered opioids and anxiolytics, which could help manage their symptoms at the end of their lives (Ouyang et al. 2020). In Sweden, a qualitative study was conducted by interviewing sixteen

physicians and fifteen nurses in oncology and hematology centers to explore how physicians and nurses perceive the concept of ethical competence in DNR decisions. The study revealed that the physicians and nurses who took part in the study had more or less the same views on their ethical competency regarding DNR decisions, what they should comprise, and how they should be developed (Pettersson et al. 2020). A quantitative study was conducted in Portugal on the approach to withholding and withdrawing DNR decisions between 2011 and 2016 among 1603 ICU patients. The researchers found that the main reason for treatment limitation was the poor prognosis of patients' diseases, which may affect the DNR decision (Monteiro, 2019).

When DNR orders are requested by physicians, not all DNR patients receive appropriate care from healthcare professionals in both critical care and general ward units. Several studies have highlighted the fact that the workload and lack of specialized knowledge on end-of-life care results in the abandonment of care for DNR patients. Notably, the literature highlights that healthcare professionals' views, feelings, and experiences of caring for DNR patients vary (Sok et al. 2020). Although some studies have focused on assessing physicians' perceptions and attitudes toward caring for DNR patients, very few studies have focused on the lived experiences of nurses providing end-of-life care for DNR patients. The researchers were unable to locate any study that explored the experience of both nurses and physicians caring for DNR patients in both ICUs and general care units in the context of Saudi Arabia.

Aim

To explore the experience of healthcare providers in caring for patients with Do-Not-Resuscitate orders at the Ministry of Health (MOH) hospital

Research Question

What is the experience of healthcare providers in caring for patients with Do-Not-Resuscitate orders at MOH??

MATERIALS AND METHODS

Research Design

A descriptive qualitative design was employed to explore the experiences of healthcare providers caring for DNR patients. A qualitative research approach is used to understand and describe human experiences, behavior, or a particular phenomenon (Gray et al. 2017). Qualitative research focuses on experiences, feelings, and the content of people's expressions and articulations; therefore, it is based on subjective data that are difficult to code numerically (Polit and Beck, 2018). More importantly, phenomena embedded in in-depth information are best revealed by using qualitative approaches that posit "why" and "how" type questions.

Study Setting

Data were collected from the intensive care and medical wards of an MOH hospital. These units are known to be involved in DNR cases. This hospital was selected as the data collection site because it is the largest MOH hospital in the Jeddah region (707-bed capacity). Notably, the hospital provides several health services in different specialties, such as ICU, cardiology, surgery, emergency, and internal medicine. Furthermore, all cases are seen by qualified medical professionals and nursing staff from different specialties. The hospital has Joint Commission International (JCI) and Central Board for Accreditation of Healthcare Institutions (CIBAH) accreditation.

Sampling

The sample for this study consisted of both nurses and physicians working in intensive care as well as medical wards. Nurses were selected to explore their own experiences, feelings, and challenges regarding the provision of nursing care for DNR patients. Furthermore, physicians were recruited to participate in this study to explore their experiences regarding how DNR orders and decisions are made, as well as the influence of DNR orders on patients' relatives. Hence, a purposive sampling technique was used to select study participants. This sampling technique involves researchers selecting participants who can provide specific information and explore crucial issues relevant to the study phenomenon (Polit and Beck, 2018).

Inclusion criteria

Nurses

Registered nurses working in ICUs, step-down units, and medical wards which involved DNR cases.

Physicians

Consultants working in ICUs and medical wards, who dealt with DNR cases.

Sample Size

In qualitative studies, the sample comprises only a small number of participants to achieve in-depth exploration and investigation of the phenomena being studied. Furthermore, in qualitative studies, sample sizes must achieve data saturation. In this study, data saturation was achieved using a sample size of twenty-one participants (Table 1).

Table 1: Sample size of the study participants

Unit	No. of nurses	No. of consultants
ICU	8	3
Medical wards	8	3
Total	16	6

Data Collection Method

Data were collected using semi-structured interviews. One-to-one interviews were conducted to explore,

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describe, and explain the experiences and views of the participants regarding the care they provided to DNR patients. In qualitative studies, interviews provide in-depth information that helps researchers understand the study phenomena (Gray et al. 2017). Notably, interviews are deemed to be the best method to collect data when there is insufficient information about the study phenomena, and to explore sensitive topics in more detail (Polit and Beck, 2018). Additionally, DNR policy was reviewed to confirm the data obtained from the participants.

Instruments

An interview guide was developed for individual interviews by reviewing the literature to include the most relevant questions. The aim of using probe questions was to guide the researchers to clarify the participants' responses and provide more detailed answers. The questions included in the interview guide regarded the participants' experiences of caring for DNR patients, the process of issuing a DNR order, the role of the patient and their family in this decision, and the impact of DNR orders.

Data Collection

The first step in the data collection procedure was to obtain ethical approval from the MOH hospital. Once the approval was obtained, potential participants who met the inclusion criteria were recruited through unit meetings or were directly contacted using a list of names made available by the head nurse of the unit for nurses and head of department for consultants who were acting as gatekeepers. The researchers gave potential participants all relevant information on the study, including its research topic and aim, the makeup of the study sample, and the study's significance. Nurses and consultants who showed an interest in participating in the study were contacted to ensure their availability and to arrange times for the interview. Eight individual interviews were conducted with nurses and three with consultants in each unit. All interviews were conducted in English, were held at the hospital, lasted approximately 30–45 minutes, and were recorded and transcribed.

Data Analysis

Data were analyzed using thematic analysis to identify themes (i.e., patterns in the data that were important or interesting). The process involved reading and rereading the interview transcripts to generate initial codes, looking for themes, and defining and reviewing themes to answer the research questions (Maguire and Delahunt, 2017).

Ethical Considerations

Ethical Approval

The researchers obtained ethical approval to collect data from an MOH hospital with a reference number (Research No:1458; Ref No: H-02-J-002).

Anonymity and Confidentiality

Avoiding deception and protecting privacy are the main ethical principles that should be considered when conducting research (Polit and Beck, 2018). In this study, the identities of the participants were not revealed while collecting and analyzing the data (Gray et al. 2017). The researchers removed all the names of the participants and assigned them codes. Information sheets were provided to the participants that explained all information on how confidentiality was to be maintained throughout the study. Participants were also informed that their participation was voluntary.

Informed Consent

The researchers explained the aims of this study. Moreover, the participant information sheet provided to all participants fully explained the aims and objectives of the research study and the benefits and potential risks to the research participants. Therefore, all participants had the necessary information to base their decision on whether to participate in the study. Before the interviews, the participants had adequate time to clarify any points, ask questions to be able to participate in the study, and sign the consent form.

RESULTS

The following four main themes emerged from the data:

Meaning and definition of DNR

This theme was explained by defining DNR orders and describing its cases in the target hospital. All healthcare providers working in the ICUs and medical wards agreed that a DNR order is defined as no resuscitation: "It's suggesting that the patient arrested, no heartbeat at all we cannot resuscitate ... it means we cannot do cardiopulmonary resuscitation." (SN1-ICU7); "DNR means do not resuscitate." (DR1-MW)

According to the hospital's DNR policy, a DNR order means that "all procedures for resuscitation are not initiated, i.e., in the event of cardiopulmonary arrest do not call the CPR Team, or initiate chest compression, defibrillation, cardioversion, intubations, ventilation, or administer advanced cardiac life support medications." However, it was highlighted that DNR policy is the same in any hospital in Saudi Arabia as reported by consultants: "The DNR policy in our country, Saudi Arabia, is the same in all hospitals under different healthcare organizations." (DR1-ICU)

DNR cases were presented differently by the participants. For instance, in the ICU, most DNR patients were diagnosed with brain death: "DNR means that the patient has brain death and there is no response to any treatment." (SN2-ICU4)

In the medical wards, patients with multi-organ failure or dysfunction were the most common DNR cases: "DNR order is always for the patient who has multi-organ

disease, and failures, and bad prognosis, and there is not any hope from the doctor's side that the patient will get improvement." (SN3-Medical11). Nevertheless, brain damage, multiple organ failure, terminal or advanced cancer, advanced chronic liver disease, advanced heart disease, and pulmonary disease were all highlighted in the DNR hospital policy as acceptable reasons for DNR orders. However, all consultants in the study agreed that a DNR case can be any case that does not respond to medical interventions "DNR can be any case with any diagnosis that does not respond to all medical interventions and not improved." (DR3-ICU)

All staff nurses reported that the DNR order had to be issued and signed by three physicians. In ICUs, a DNR order form must be completed and signed by the most responsible physician (MRP), who must be a consultant, and two other consultants in the ICU, and it must also be signed by the head of the ICU department. In the medical ward, the DNR form must be signed by three consultants, including an ICU consultant, and by the head of the medical department. It was emphasized that if the form does not have all the above-mentioned signatures, then the nurses will resuscitate the patient: "We have a DNR paper, it has to be signed by three consultants. If these people are not available, doctors of related field like ICU doctors, whether resident specialist, it has to be three people sign in. If it is not three, it is not valid, so we have to resuscitate the patient." (SN1-ICU7)

This course of action is confirmed in the hospital's policy: "The treating physician (consultant level) will request another two (2) referral trustworthy, specialized physicians (consultant level) from the same or related sub-specialty to review the case carefully and document and sign their opinions in relation to the decision in the DNR status noted in the progress notes of the patient's medical records."

Therefore, a DNR is not an independent decision taken by a physician; it must be a decision agreed upon by all the physicians involved in the patient's care: "Yes, of course they will ask, they will discuss with everyone. It is not an independent decision; they will discuss with everyone." (SN4-ICU8)

Nurses were asked about their contribution to the process of issuing a DNR order, specifically if they were involved in the decision to issue a DNR order. The ICU nurses stated that they were involved in the decision to issue a DNR order only in terms of monitoring the case and updating the physicians about the patient's condition, which would assist the physicians to decide on the DNR order: "They are involved, they monitor the patient, sometimes stay with the patient, so they know everything about the patient, so they get the notes about the patient. This notes, the doctor will evaluate it, then they start to make a plan about DNR." (SN5-ICU9). This was confirmed by the ICU consultants who reported that nurses participate in the DNR orders only by providing crucial information to the consultants in every shift:

"Nurses contribute to DNR orders by giving us the critical information about the patient progress while monitoring the patient in every shift." (DR2-ICU)

In medical wards, the nurses reported that they were not involved in the decision to issue a DNR order, as it was the physician's responsibility: *"For the decision, we cannot tell anything regarding that one because not our job description; this is the doctor's job description ... We will just carry out the orders and we will follow our previous care of the patients."* (SN3-Medical11). Nevertheless, consultants in the medical wards highlighted that nurses' information about the case is particularly important, and based on this information, the DNR order can be taken: *"Nurses have a role in this because we do DNR order for all patients based on nurses' vital information about the case."* (DR1-Medical)

Interestingly, there were also differences in nurses' views regarding their awareness of the hospital's DNR policy. For instance, ICU nurses revealed that there is a DNR policy in the hospital, but they were not aware of its contents. As reported by one of the staff members: *"I am not sure about the policy, but this is the thing we are following. There are some criteria for the patients under DNR."* (SN6-ICU2). It also became evident that nurses in the medical ward were also not completely aware of the DNR policy; they were only aware of and concerned about the DNR order form: *"There is no policy ... the most important is the form to be signed by MRP team and consultant and physicians."* (SN6-Medical6)

Experience of healthcare providers in caring for DNR patients

This theme emerged during discussions of the challenges, beliefs, and feelings regarding the personal experiences of both nurses and consultants with DNR orders in the hospital. Both the ICU nurses and nurses working in the medical units believed that the DNR policy was merciful for the patients: *"I really agree with the hospital policy. If there is no chance of survival, we can give that patient a peaceful death."* (SN7-ICU10). Furthermore, both ICU nurses and nurses in the medical units reported that their major challenge was the limitation imposed on them by the hospital's DNR policy on the information they can provide to the patients' families. In the nurses' words, it is difficult for them *"to see how they are struggling. That is really difficult for us to see because they are in their late life."* (SN7-ICU10); *"We should not discuss anything with the patient's relative regarding the patient's condition."* (SN3-Medical11). The majority of ICU and medical unit nurses stated that they felt bad for patients with a DNR order and the fact that they cannot do anything when DNR patients arrest: *"We feel bad because DNR means if the patient arrests, we cannot do anything. We will just observe the patient until he dies."* (SN3-Medical11). By contrast, because the majority of patients who are issued with a DNR are already dying, a nurse from the ICU stated that they do not have any feelings:

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"Our feelings might not be too much because we already see a lot of people dying, as a feeling we are not feeling." (SN5-ICU9)

By comparison, consultants revealed that DNR orders are the best decision for patients' relief: *"DNR order is the best decision for the patient when you cannot do anything more and patients are not showing progress."* (DR2-Medical). Furthermore, all consultants in both ICUs and medical wards commented on informing the patient's relative as the encountered challenge during the DNR order: *"The only challenge is the patient's family when they are notified about the DNR order, and the way they react and accept our decision."* (DR1-ICU). Additionally, it was mentioned that the challenge in informing patients' relatives incorporated the misunderstanding of the DNR order, as there is a misconception that resulted in disagreement. In this context, it was highlighted that raising awareness regarding DNR orders is crucial and has an influence on their agreement: *"For all relatives who showed disagreement, they are being informed and provided with the information regarding DNR order and that the patients will receive a full care and will not left without appropriate care; however, the only difference is do not resuscitate."* (DR3-Medical)

Care of DNR patients

This study showed that the care provided for DNR patients does not differ from that provided to other patients. In one of the respondents' words, *"DNR does not mean I can leave him. Patient may be DNR, but he may still live for months ... the soul is in him for months so I cannot leave him without movement and cleaning. If I ignore him, I will kill him."* (SN5-ICU9)

Moreover, consultants working in both units reported that all patients received similar care and there was no difference in the provided care for DNR and non-DNR patients: *"We spend the same time in rounds for all patients in the ICU, and there is no difference between DNR and non-DNR patients in the provided care."* (DR3-ICU); *"It is important to us after placing DNR order to continue and provide all clinical services with full medications and medical interventions for DNR patients as it is given for a regular patient; however, the main difference is do not resuscitate DNR patients."* (DR2 - Medical). However, commenting on consultants' rounds, a nurse working in the medical ward stated that some doctors did not spend much time on DNR patients or simply did not show up for their rounds: *"The doctors came in the round, but they will not take that much of time for DNR patient."* (SN9 -ICU12). Doctors working in the ICU, however, spent the same amount of time with each patient.

Some ICU nurses highlighted that DNR patients in the ICU were provided with a different type of care: *"The care isn't given to all the patients equally, patients who aren't on DNR have the chance to get better care than patients on DNR."* (SN2 -ICU4). Only a few nurses in the medical

wards stated that they prioritized the care provided to DNR patients: *"We will prioritize the more stable patients."* (SN8-Medical12). Nurses' priorities are affected by several factors, including staff shortage. Furthermore, when participants were asked if they attended the doctors' rounds, the majority commented that they did attend them and that the doctors continued to prescribe medication with the most significant difference being that they stopped ordering medical investigations *"like CT scans, x-rays no, no more ... medication they will order but investigation, not after DNR."* (SN3-Medical11)

The DNR orders and patient's family

According to hospital policy, the DNR order must be made according to established criteria and be based on the identified conditions. The policy also states that physicians are responsible for informing the patient's family about the decision to issue a DNR order.

"The MRP shall discuss in depth with both the patient who has decision-making capacity, and/or the most appropriate/responsible family member if the patient is lacking decision-making capacity, how and why the DNR decision was reached."

The interview data confirmed that the responsibility of informing the family regarding the DNR decision falls to the most responsible physician: *"The doctor himself is who decides, but the doctor is going to inform them as the patient's right and the family's right."* (SN10 -ICU3). Nurses in both the ICU and the medical care units felt that all they could do is provide psychological support to the patient's family, answer the families' questions regarding the case, and allow family members to enter the patient's room during visiting hours: *"As nurses, the main thing we can give is psychological support only."* (SN11 -ICU2); *"We can allow them to do their own care; like the family is allowed, there was visiting hours for them, and we consider them like that."* (SN4-ICU8); *"We can give psychological support, we can discuss the investigations normal or not normal, we can inform about the case, why admit it here; we can inform the vital."* (SN3-Medical11)

DISCUSSION

This study aimed to explore the experiences of healthcare providers caring for DNR patients at MOH hospital. The results of this study demonstrated that the DNR order is a medical decision, in which nurses are not involved. However, nurses in the ICU believed that they were involved in the DNR process by monitoring the patient and updating the physicians on the patient's condition. A similar finding was revealed in Pettersson et al.'s (2020) study, which concluded that the DNR decision is the responsibility of physicians, while the nurses' role is confined to participating in the case discussion. This may be because nurses working in Saudi Arabia have a low autonomy level and are not allowed to participate in clinical decision-making related to a patient's condition, particularly in MOH hospitals.

Furthermore, this study showed that few nurses working in medical wards were unaware of the content and details of the DNR policy. This has not been highlighted in previous studies. This finding can be explained by the fact that according to hospital procedures and policy, the DNR decision in the target hospital is taken by the physician, and the nurses are obliged to follow the order without questioning it. Moreover, nurses working in medical wards do not expect too many DNR cases of DNR.

Additionally, this study revealed that discussing DNR decisions with the patient's family is the main challenge. When there is a DNR order, nurses are not in a position to provide information regarding DNR decisions. This finding contradicts that of a previous study (Noome et al. 2016), which suggested that nurses play a crucial role in sharing a patient's values and explaining the patient's condition to their family within the context of the DNR decision. This finding is related to the fact that nurses at the target hospital were not allowed to inform or discuss DNR decisions with the patient's family according to the hospital's DNR policy.

Similarly, discussing DNR decisions with the family was highlighted in the current study as the main challenge for consultants due to misunderstandings. This was also reported in a previous study conducted in Saudi Arabia, which revealed that there is variation in the patients' families' knowledge and opinions about DNR decisions that require a greater explanation from physicians about DNR orders (Alsaati et al. 2020). This finding can be explained by the fact that this hospital provides patient care for the general population; therefore, not all relatives understand and or are aware of the meaning of DNR orders. Furthermore, patients' families' have different educational levels as well as different levels of knowledge regarding DNR orders, both of which play crucial roles in understanding the meaning of DNR orders.

Moreover, the nurses interviewed in this study reported that they were uncomfortable providing care for DNR patients. This was consistent with the findings of another study, which suggested that ICU nurses were more likely to experience depression while caring for DNR patients than nurses working in general care units (Sok et al. 2020). An explanation for this might be that ICU nurses work in a more stressful environment than do nurses working in general care units. Furthermore, there was a higher incidence of DNR cases in the ICU than in general care units, suggesting that ICU nurses have more experience in caring for DNR cases than do nurses working in general care units.

Furthermore, the results of this study indicate that the care provided to DNR patients is not equal to that provided to other patients. As mentioned in the literature review, nurses perceived that the level of care received by DNR patients is not at par with the normal nursing care received by other patients (Nankundwa and Brysiewicz, 2017). This result may be explained by the fact that some

nursing staff believed that DNR patients do not have the right to optimal nursing care because such patients have lower odds of survival. Some nurses also revealed that DNR patients are sometimes not prioritized for nursing care when there is a shortage of staff, although no data support this finding in existing literature. As a consequence of nursing shortages in the target hospital, the nurse–patient ratio was 1:10 in general care wards and 1:2 in the ICU, resulting in a lack of time and a heavy workload for nurses who have to prioritize care. Moreover, one unanticipated finding was that some physicians skimmed on their daily rounds for patients with DNR orders, but this result has not been supported in the literature. An explanation is that some physicians may feel that spending time and effort on DNR patients who do not have high odds of survival is a waste of time.

In this study, the nurses emphasized that the only support they could provide to DNR patients' families was psychological; social workers and physicians provided further support. These findings do not support the findings of a previous research (Thompson et al. 2006), which stated that caring for DNR patients' families by providing psychosocial care and informational support plays a vital nursing role. This inconsistency may be due to nurses' lack of strong fundamental palliative care knowledge, their discomfort when discussing issues related to dying patients, their lack of understanding of the impact of patients' families' involvement in the scope of care, and the fact that the DNR policy in the target hospital excluded the supportive role of the nursing staff. A major limitation of this study is that it took place in only one MOH hospital in Jeddah, and therefore reflects only the experiences of nurses working there. Moreover, the severe shortage of nurses in the hospital influenced their ability to participate in the study, as many nurses could not spare time to participate in the study.

CONCLUSION

This study aimed to explore healthcare providers' experiences' in caring for DNR patients at an MOH hospital. The findings demonstrated that there are some differences between the experiences of nurses working in the ICUs and medical wards that stem from the differences in nursing care provided to DNR patients in the two units. Furthermore, nurses working in both the ICU and medical wards were limited to providing only psychological support to the families of DNR patients, while the misunderstanding of DNR orders among patients' families was highlighted as a challenge among consultants in both ICU and medical unit. Thus, there is a need to train all healthcare providers to collaborate as a team when these complex decisions need to be made. Healthcare professionals also need to be trained further on how to support DNR patients' families by providing, for example, family group sessions that will help family members to better understand the condition of the patient and not feel excluded from the decision-making process.

In addition, the nurses' role within the DNR policy should be updated to allow them to provide adequate care to DNR patients and their families. Nurses should also be aware of the contents of DNR policies. Further research is recommended to provide insights into the sources of unsuitable care provided by healthcare professionals.

CONFLICT OF INTEREST

The authors declared that present study was performed in absence of any conflict of interest.

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AUTHOR CONTRIBUTIONS

MAB, NAA, LYA, YAB, LRZ designed the study, wrote the study proposal, data analysis, write original draft of the manuscript. MAB, NAA, LYA, YAB, LRZ, NSA involved in data collection and reviewing and editing review manuscript. All authors read and approved the final version.

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