Analysis of Design Form "*Do Not Resuscitate*"

Ratih Kumala Dewi
Faculty of Health Science
Universitas Nasional Karangaturi
Semarang, Indonesia
ratih.kumala@unkatur.ac.id

Rano Indradi Sudra
Faculty of Health Science
Universitas Nasional Karangturi
Semarang, Indonesia
rano.indradi@unkartur.ac.id

ABSTRAK

Do Not Resuscitate (DNR) is an instruction/ for health care professionals not to conduct heart resuscitation on the case of cardiac arrest and/or respiratory arrest. There had been 1051 DNR decision out of 4182 patients in all healthcare facilities in Massachusetts from 2001 to 2007. However, there has not been explicit regulation to control DNR practice in Indonesia. Approval medical consent which is commonly known as informed consent is one of the required procedure before DNR decision is taken. Inadequate informed consent may cause grievance from the patient and their family members, or worst, lawsuit against the doctors. This study aims to analyze the DNR form design in terms of clarity and consistency of the content in one of the public hospitals in Indonesia. This study utilizes observation research method to analyze the form and refer the analysis to the existing references. The result found several obscurities and inconsistency of the form content which might potentially cause misinterpretation. Besides, DNR form has not been complemented with the filling instruction nor Standard Operating Procedure (SOP). As a result, it might possibly lead to legal dispute in the future. Thus, it is suggested that the form design needs revision, filling instruction is crucial to formulate, and the SOP is critical to produce.

Keywords: *form design, DNR, clarity, consistency*

I. INTRODUCTION

Every patient who comes to the hospital must follow the rules in force at the hospital. If the patient who comes only for outpatient treatment, the legal aspect he receives is relatively simpler than if the patient must be treated. This shows that every patient who gets health services has the right to get or refuse treatment (Werdikesni & Pujihastuti, 2008)

The development of science and technology in the health sector, on the one hand, can answer the demands of increasingly complex health service needs. On the other hand, technological developments can also raise new problems, namely the risks that arise as a result of its utilization if the application is not in a safe system. This causes health services to always be overshadowed by the risk of errors or inaccuracies in services that can adversely affect patients, health workers themselves and institutions that provide health services. Hospitals must be able to provide protection for the safety of patients, the community, the hospital environment, and existing human resources.

Lately, the health team or medical team, especially doctors, still often experience dilemmas in the medical code of ethics. Where doctors are faced with a difficult choice whether to do or not to do and whether or not it is a risk to patient safety. One of the cases that is often found is Do Not Attempt Resuscitation (Mohammad Mustaqim bin Malek, 2018)

Do Not Attempt Resuscitate (DNAR) is an order not to perform Cardiac Pulmonary Resuscitation (CPR) for health workers or the general public if there is an emergency problem with the patient's heart or the cessation of breathing.. DNR generally means that the patient will not receive CPR at the time of the Cardiac Arrest. The goal of cardiovascular emergency services or CPR is to maintain life and return patients from clinical death (Schears, 2004)

DNAR is an order notifying medical personnel not to perform Cardiovascular Resuscitation. This means that doctors, nurses,

and emergency medical personnel will not attempt emergency Cardiac Resuscitation if the patient's breathing or heart stops. DNR is a message for health workers or the general public not to try to perform or provide relief measures in the form of CPR (cardiopulmonary resuscitation), this order is written at the request of the patient or family but with the approval of the responsible doctor. medical team. DNR can be done based on consideration of the patient's health status and cost of care (Weiss & Hite, 2000).

Patients and their families who request to do DNR on patients have autonomous rights that must be respected which sometimes becomes a dilemma for the health team. However, on the other hand, DNR can be done if the medical team finds a fact that the patient has a low life expectancy, which is very unlikely to be helped. (Michael, 2002).

DNR decision making tends to increase every year, from 2001 to 2007 as many as 1051 patients out of 4182 all patients in all health Massachusetts received DNR procedures. ICU is the room with the largest number of DNR found.

There are no regulations that clearly regulate how DNR is carried out in Indonesia. UUD 1945 article 28 A, Law No. 29 of 2004 on medical practice article 39, KODEKI article 17 is not clear about the legal certainty that regulates DNR. Even the DNR can be considered as part of the Euthanasia effort, it can be suspected of violating the law and is subject to the KUHP pasal 344 BAB XIX concerning crimes against life (Palaguna & Indrahti, 2016)

The quality of information has an impact at all levels of the organization, namely the operational, tactical and strategic levels. The success of organizational functions and results depends on the level of information quality within the organization (Sinitsyna, 2014). Information quality is one of the key determinants of organizational quality in making decisions and actions. The quality of medical record document information is an important requirement for the survival of the hospital. Accuracy and suitability of medical record document information will assist the hospital in making claims to insurance providers for service costs incurred by the hospital.

Good quality information can be useful as a basis for good decisions at all levels of the organization. Information quality at the operational level is very important for customer and employee satisfaction. Information quality at the tactical level is very important for decision making, and at the strategic level organizations require high quality information for define and implement a business strategy (Gorla et al, 2010). The quality of information in medical record documents is very important for the survival of the hospital. Hospital strategic planning will run well if it has a strong foundation of quality medical records.

One of the things that must be considered is the quality aspect of the information regarding medical action approval. Medical Action Approval or better known as informed consent is one of the obligations that must be done by doctors before taking medical action. Approval or rejection of a medical action to be performed by a doctor must be obtained from the patient. Inadequate or inadequate implementation of the Approval of Medical Action or in accordance with the procedure can cause complaints and / or claims from both the patient and family and can cause legal problems for doctors. The results showed that inadequate consent to medical action was one of the most frequently reported cases of medical malpractice by patients. The Australian study reported that 3.4% of the 7846 cases of malpractice and 11.5% of the 1898 patient complaints were related to the Approval of Medical Action from all specialists and general practitioners.

 ISBN : 978-623-95806-0-5 (PDF)

II. METHOD

This study uses a descriptive research method using a qualitative approach. This research was conducted with the aim of making a description or descriptive of a situation objectively and used to solve or answer the problems being faced in the current situation. (Notoatmodjo, 2010).

III. RESULTS AND DISCUSSION

Quantity And Quality Analysis Of Completed DNR Forms

Completeness of filling out the form on one of the DNR Formulas in one of the private hospitals in Central Java on the identity filling which is completely filled in 93.7% and the one which is not filled in is 6.3% For the average accuracy of filling in the DNR Forms on identity filling which are filled in exactly 90.6% and those that are not filled in exactly 9.4%. On average, the completeness of the DNR Forms on authentication filled in completely 91.4% and 8.6% not filled.

According to MENKES RI NO.129 / MenKes / SK / II / 2008 regarding minimum service standards for completeness of filling in Informed Consent, namely 100%. The correct filling is very important, if the wrong one can cause harm to the patient and could force the facility and / or service provider to face criminal and civil charges. The range of values is included in the following good categories, the completeness of filling in the identity of 93.7% is in the good category, the completeness of filling in authentication is 91.4%, the completeness of filling in the type of information is 77.5%. Researchers argue that the minimum service standard for completing the DNR Informed Consent Form must be 100% because the completeness of filling out the DNR Informed Consent Form is very important because it will be detrimental to the patient and can face criminal and civil charges.

Policies and Standard Operating Procedures for Filling in DNR Forms in Hospitals

Based on the results of research conducted by researchers to informants at the "PW" Hospital, there is no policy regarding the completeness of filling out the DNR Informed Consent form while the SOP already exists. SOPs basically contain standard operating procedures that exist within an organization that are used to ensure that every decision, step, or action, and use of processing facilities carried out by people in an organization, has been running effectively, consistently, standards, and systematic. Policies are provisions that contain principles to guide ways of acting which are planned and consistent in achieving certain goals. If the organizational and management policies do not comply with the established standards or are not supportive, it will be difficult to expect good quality health services.

One private hospital in Central Java has a standard operating procedure in deciding DNR in patients. Standard Operating Procedures include several points, namely before it is decided that there is a comprehensive explanation on the family of the procedure, including ensuring that the patient's condition must be in a terminal state, providing information to the patient or family, and communicating the Doctor in Charge of Services about requests and DNR decisions, the Doctor in Charge of Services as well as patients / families discussing the DNR decision, and finally giving Informed Consent and installing the DNR bracelet.

The researcher argues that there must be policies and SOPs, basically standard operating procedures that exist within an organization and without the complete sop policy it will be difficult to do because it contains the principle of directing ways of acting that are planned and consistent in achieving goals.

From the explanation above, it is clear that the result of a patient doctor's therapeutic

transaction is that the rights and obligations of each party (doctor-patient) are born. One of the conditions for a therapeutic transaction to be legal according to the law is consent, which is consent to be treated using certain methods / techniques / therapies that have been mutually agreed upon based on complete and accurate information about the illness he or she is suffering from regarding the possible consequences that could arise, which is ultimately based on this information determines its own attitude towards one of the many methods / techniques / therapies that are informed to him.

This principle of patient autonomy is considered the basis of the informed consent doctrine. Medical action against a patient must obtain approval (authorization) from the patient, after he has received and understands the required information. morally or legally, no one, whether doctor or patient, can do anything to a person's body without the consent of the owner of that body, because that is an act of violating ethics, civil law and criminal law. Therefore, only the patient himself has the right to determine what is best for himself.

According to Khan (2010), informed consent is an approval of medical action for something that can be done to him. In fact, Do not resuscitate (DNR) is an order not to perform Cardiac Pulmonary Resuscitation (CPR) for health workers or the general public if there is an emergency problem in the patient's heart or the cessation of breathing. DNR generally means that the patient will not receive CPR at the time of cardiac arrest. So there are no rescue medical actions in the DNR(Amestiasih & Nekada, 2017)

Causes of Incomplete DNR Informed Consent Form at "PW" Hospital

Based on the results of interviews with authorized officers about the causes of incompleteness of the DNR Informed Connections, it can be concluded that the patient's family does not exist. Medical records must be made immediately and completely completed after the patient receives services and the following conditions: any consultation performed on the patient no later than 1X24 hours must be written on a medical record sheet. The researcher argues that the officer who is responsible for filling out the DNR Informed Consent still lacks awareness of the completeness of the Informed Consent that should be filled in completely, because this involves medical actions that will be given to patients, and legal actions that can occur at any time if the results of the operation are not. as expected by the patient and the patient's family.

The doctor must clearly write and sign the DNR order in the patient chart. Progress records should include medical facts and opinions that underlie the setting and summaries of discussions with patients, consultants, staff, and families. The request status should be changed if necessary due to the patient's condition. Everyone involved with patient care should be informed of the DNR request and its rationale. Because research has shown that DNR means different things to different practitioners, physicians writing requests must be careful to document the specific requirements of the requests. Decisions to withhold or withdraw interventions other than DNR should be recorded by writing a special order instead of using the DNR sequence to cover various decisions. The writing of a DNR request should have no direct bearing on any treatment other than CPR (Butler et al., 2003)

Physicians should remember that many patients for DNR requests persist in waiting for the patient request approval letter to be discharged from the hospital. If the patient is re-admitted, DNR requests that are on the patient's chart of previous admissions should be reviewed with the patient and surrogates and in clear medical indications. If the DNR order has not been written, the patient is considered to be

 ISBN : 978-623-95806-0-5 (PDF)

"full code". general, home workers and nurses who want to know the status code of a seriously ill patient or by replacement, especially if the patient's admission is sudden and unexpected (Han & goleman, daniel; boyatzis, Richard; Mckee, 2019) if the patient for whom the status code has not been determined has had a heart attack, reasonable exhalation efforts should apply, except in an instance of overt physiological futility. DNR orders for patients must be written either in the patient's medical record or in the notes the patient carries on a daily basis, in the hospital or nursing home, or for the patient at home. The DNR order at the hospital notifies medical staff not to attempt to revive the patient even in the event of cardiac arrest. If the case occurs at home, a DNR order means that medical staff and emergency personnel should not undertake resuscitation or transfer the patient to the hospital for CPR.

IV. CONCLUTION

The result found several obscurities and inconsistency of the form content which might potentially cause misinterpretation. Besides, DNR form has not been complemented with the filling instruction nor Standard Operating Procedure (SOP). As a result, it might possibly lead to legal dispute in the future. Thus, it is suggested that the form design needs revision, filling instruction is crucial to formulate, and the SOP is critical to produce.

V. REFERENCES

Amestiasih, T., & Nekada, C. D. Y. (2017). Hubungan Pengetahuan Perawat Tentang Do Not Resuscitation (Dnr) Dengan Sikap Merawat Pasien Di Icu Rsud Panembahan Senopati Bantul. *Jurnal Keperawatan Respati Yogyakarta*, *4*(2), 138. http://nursingjurnal.respati.ac.id/index.php/JKRY/index

Butler, J. V., Pooviah, P. K., Cunningham, D., & Hasan, M. (2003). Improving decision-making and documentation relating to do not attempt resuscitation orders. *Resuscitation*, *57*(2), 139–144. https://doi.org/10.1016/S0300-9572(03)00029-7

Han, E. S., & goleman, daniel; boyatzis, Richard; Mckee, A. (2019). 済無No Title No Title. *Journal of Chemical Information and Modeling*, *53*(9), 1689–1699.

Mohammad Mustaqim bin Malek. (2018). *Arahan Do Not Resuscitate (DNR) Menurut Perspektif Hukum Islam*. *UM*.

Palaguna, S. K., & Indrahti, S. (2016). PRESERVASI ARSIP REKAM MEDIS DI RUMAH SAKIT UMUM DAERAH dr. SOESELO KABUPATEN TEGAL. *Jurnal Ilmu Perpustakaan*, *5*(3), 341–350. https://ejournal3.undip.ac.id/index.php/jip/article/view/15277

Schears, R. M. (2004). *" Do not attempt resuscitation " (DNAR) in the out-of-Hospital setting '" Do Not Attempt Resuscitation "' (DNAR) in the Out-of-Hospital Setting*. *August*, 2–5. https://doi.org/10.1016/S0196064404000563

Werdikesni, U., & Pujihastuti, A. (2008). Tinjauan Penggunaan Dokumen Rekam Medis Di Bagian Filing Rumah Sakit Jiwa Daerah Surakarta Tahun 2008. *Jurnal Kesehatan*, *2*(1), 18–35.

Hatta. 2008. Pedoman Manajemen Informasi Kesehatan Di Sarana Pelayanan Kesehatan. Jakarta: UI press

Notoatmodjo. 2010. Metodologi Penelitian Kesehatan. Jakarta: Rineka Cipta

INTERNATIONAL PROCEEDINGS

THE 2ND INTERNATIONAL SCIENTIFIC MEETING on HEALTH INFORMATION MANAGEMENT (ISMoHIM)

Reinforcing Health Information Management Professionals in The Industrial Revolution 4.0

[Electronic Source]

Surakarta, 19 December 2020

Online Conference

APTIRMIK Press

ISBN 978-623-95806-0-5 (PDF)