QUINTE HEALTHCARE CORPORATION

Medical – Resuscitation

Title: Medical – Resuscitation		**Policy No:**	**3.11.9**
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1. PURPOSE

To assist in the decision making process surrounding when and when not to initiate Cardiopulmonary Resuscitation (CPR) and to help understand the ethical and legal ramifications of a Do Not Resuscitate (DNR) order.

This policy was developed in accordance with the guidelines set out in the "Joint Statement On Resuscitative Interventions (Update 1995)" which was approved by the Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association, Catholic Health Association of Canada and with the cooperation of the Canadian Bar Association (1).

2. DEFINITIONS

"Cardiopulmonary Resuscitation is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardio-respiratory arrest. These measures include basic cardiac life support involving chest compressions, defibrillation, intubation and other procedures the Heart and Stroke Foundation of Ontario considers advanced cardiac life support procedures" (2).

Every patient is presumed, by current practice, to consent to cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest unless otherwise indicated (1).

"CPR is not indicated in certain situations, such as in case of terminal, irreversible illness, where death is expected, or where prolonged cardiac arrest dictates the futility of resuscitative efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity. When CPR is considered contraindicated for hospital patients, it is appropriate to indicate this on the physician's order sheet for the benefit of nurses and other personnel who may be called upon to initiate or participate in cardiopulmonary resuscitation" (3).

3. POLICY

CPR is to be performed on any person who suffers a cardiac or respiratory arrest unless:

There is a valid DNR order on the chart (1)
There is conclusive evidence that the patient is dead (2)
A member of the health care team is aware that the patient does not wish resuscitation even though a DNR order has not been documented, and that the patient was competent when the request to not be resuscitated was made (4)
A member of the health care team is aware that the patient has a terminal irreversible illness where death is expected imminently and although a DNR order has not been written, resuscitation attempts are not indicated and should not be initiated (1,4,5)

In circumstances where resuscitation attempts are recognized as not being of benefit, such as cardiac or respiratory stoppage occurring as the anticipated and imminent end of a terminal illness or in a person in a chronic vegetative state, the attending physician must clearly indicate that a plan of care has been discussed with the patient, substitute decision maker or family, before writing a DNR order (1,5).

Although in such cases, physicians are not ethically or legally required to provide treatments that are not therapeutic options, when questions regarding resuscitation have been raised by the patient, by the patient's substitute decision maker or by family, it should be documented that discussions have taken place and that an agreement has been reached that a DNR order may be written.(1,5).

In the event that resuscitation attempts are requested by a patient or substitute decision maker under these circumstances, and the most responsible physician disagrees with the request and when attempts to resolve the issue have not been successful, the physician is obliged to transfer care of the patient to another facility or care provider who is comfortable with that request (5).

A 'DNR' order:

Must be written at the request of a patient or in the case of a patient's incapacity, by their substitute decision maker(5,6,7).
Cannot be written, in general, without the consent of the patient or an incapable patient's substitute decision maker (7).
Cannot be written, in the case of terminal irreversible illness, where death is imminently expected, until a plan of care has been discussed and agreed to by the patient or by the patient's substitute decision maker or family (1,2,5).
May be rescinded at any time by a patient or an incapable patient's substitute decision maker.
Requested by a competent patient, cannot be rescinded by a substitute decision maker without the patient's permission (6).
Will be reviewed from time-to-time as a patient's condition changes.
May be temporarily suspended with the patient's or substitute decision maker's consent, under special circumstances, such as during palliative surgery where cardiopulmonary support is an essential part of the procedure. The reason for the suspension and the expected duration of the suspension must be clearly documented on the patient record. (8).

In the event that a DNR order has been requested by a patient, substitute decision maker or family, and the most responsible physician disagrees with that request and when attempts to resolve the issue have not been successful, the physician is obliged to transfer care of the patient to another facility or care provider who is comfortable with that request(5).

Although it is recognized that a patient may seek help from others when making clinical decisions, substitute decision makers and family are not in a position to advocate on behalf of a patient unless the patient has been declared incompetent or the patient officially abdicates that power to them (6).

Contextual Issues:

When anticipating a decision that resuscitation is not indicated or when responding to a request for a DNR order, the physician with the help of the health care team, should establish:

The patient's capacity to understand the clinical situation, the ramifications of CPR and all it entails and an alternative plan of care should a DNR order be requested. To avoid confusion, and to promote consistency, the definition of CPR outlined above should be employed (6,7).
The existence of advance directives, living wills or powers of attorney (6,15) In the case of patients lacking capacity, who has the power of attorney or who is the most appropriate substitute decision maker (7).
The patient's family and friends who are important to them and from whom they might seek advice and comfort (9).
That the DNR and other plan of care orders are clearly written, dated and timed (4,5).
That the clinical circumstances surrounding the decision to write a DNR order or the medical findings supporting the conclusion that the patient is terminally ill or in a permanent vegetative state, are clearly documented (4,5).
That in the event of a change in clinical condition, a DNR order has been appropriately re-evaluated (1,4,5).
That any conflicts arising have been resolved and the resolution process documented (10).
That the patient and family and friends with consent, have been advised that in terminal clinical situations all efforts will be made to keep the patient comfortable; that pain and other symptoms will be managed and all other supportive services will be made available to the patient and family (1,4,5).

Conflict Resolution:

Physicians and staff should work to bring about consensus concerning treatment plans among the members of the health care team.
Any conflicts among team members should be addressed in the absence of the patient or substitute decision maker and family.
Nurses disagreeing with a plan of care should conduct themselves in accordance with the Practice Guideline set out by the College of Nurses of Ontario (11).
To avoid conflict between a patient or substitute decision maker and the health care team, the physician should communicate in a timely manner, treatment options, the availability of supportive services and palliative care resources.
Discussions in this vein should be clearly documented in the patient's record.
When conflict arises the physician should offer the patient or substitute decision maker, a referral to another professional with expertise in the relevant area, and should be prepared to facilitate the obtaining of a second opinion.
The physician should also offer the patient access to any mediation, arbitration or adjudication processes that are indicated and this will also include consultation with the bioethics committee.
When a physician finds it necessary to transfer care of a patient because of unresolved conflict, it must be done in compliance with the dictates of the College of Physicians and Surgeons (12).

Capacity to Consent (13,14,16):

"An individual who is able to understand the nature and anticipated effect of proposed medical treatment and alternatives, and to appreciate the consequences of refusing treatment, is considered to have the

necessary capacity to give valid consent." (13).
"The determination of capacity in a minor has become the extent to which the young person's physical, mental and emotional development will allow for a full appreciation of the nature and consequences of the proposed treatment, including the refusal of such treatments. The legal age of majority has become progressively irrelevant." (13).
"Many individuals who may be mentally infirm or who have been committed to a psychiatric facility continue to be capable of controlling and directing their own medical care. It, again, depends on whether the patient is able to appreciate adequately the nature of the proposed treatment, its anticipated effect and the alternatives. Physicians should be generally familiar with the applicable mental health legislation in their jurisdiction". (13).

APPENDICES AND REFERENCES

References:

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