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| |  |  |  | | --- | --- | --- | | **Huron Perth Healthcare Alliance** | | | | **1. Clinical Policies and Procedures** | Original Issue Date: | January 30, 2019 | | **Resuscitation Status for Admitted Inpatients** | Review/Effective Date: | July 27, 2020 | | **Approved By: VP People and Chief Quality Executive** | Next Review Date: | July 27, 2022 | |
| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
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| **PURPOSE**  The purpose of this policy is to provide guidance for providers regarding the known and or expressed wishes of a patient regarding resuscitation.  **POLICY**  The Huron Perth Healthcare Alliance (HPHA) recognizes that resuscitation decisions and discussions can be difficult for patients/Substitute Decision Makers (SDM), their families, and the health care team.  Patients have a right under the *Health Care Consent Act* to give or refuse consent to a proposed treatment, or, where the patient is incapable with respect to the decision, to have their Substitute Decision Maker(s) give or refuse consent on their behalf.  HPHA also recognizes its health care providers have no obligation to offer intervention/treatment (including resuscitative measures) that is medically futile and/or potentially harmful. This policy aligns with [College of Physicians and Surgeons of Ontario (CPSO) policy](https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Car) relating to the planning for and provision of quality end of life care.  HPHA recognizes that these principles can at times give rise to conflicting options, and has policies and processes in place to support patients, their families and health care providers in resuscitation discussions and decisions to ensure that:   * Resuscitation discussions occur in a timely and sensitive manner. * Decisions regarding the range of treatment options offered to a patient are consistent with professional standards and expectations, and the principles and obligations under the *Health Care Consent Act*, where applicable. * Patients’ rights under the *Health Care Consent Act* are recognized and honoured. * Discussions and decisions are appropriately documented and effectively communicated to the health care team. * The health care team and patients/SDMs are aware of and have timely access to mechanisms for resolving complaints, including the hospital’s conflict resolution process.   **A Do Not Attempt Resuscitation (DNAR) order should in no way affect active treatment.**  An existing Resuscitation Order is never modified. Should the patient/SDM’s decision change, a new Resuscitation Order will be written.  This policy applies to adult inpatients 50 years and older and younger patients as clinically indicated.  Patients in the Mental Health and Maternal Child units and those admitted for elective surgery are not mandated to have a Resuscitation Order Set completed unless co-morbidities indicative of a DNAR conversation are present.  **DEFINITIONS**  **Allow Natural Death** - applies only when death is about to occur. Refers to decisions to not have any treatment or procedure that will delay the moment of death; comfort measures are provided ([OMA Glossary of Terms: End of Life](https://content.oma.org/wp-content/uploads/eolc_definitions.pdf)). [hyperlink]  **Attempt Resuscitation:** See Resuscitation  **Do Not Attempt Resuscitation (DNAR)**: refers to a written medical order that documents a patient’s decision regarding his/her desire to avoid cardiopulmonary resuscitation (CPR). DNAR should not be interpreted as direction to not treat; it is specific only to CPR ([OMA Glossary of Terms: End of Life](https://content.oma.org/wp-content/uploads/eolc_definitions.pdf)). [hyperlink]  **Levels of Benefit** –   * Patient is Likely to Benefit - There is a reasonable likelihood that CPR and other life support will restore and/or maintain organ function. The likelihood of the person returning to his or her pre-arrest and life-support condition is at least moderate. * Benefit to Patient is Unlikely or Uncertain - It is unlikely that or uncertain whether CPR and other life support measures will restore organ function. The subsequent prognosis is poor or uncertain and the likelihood of adverse consequences is high. * Patient Almost Certainly Will Not Benefit - There is almost certainly no chance that the person will benefit from CPR and other life support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be unable to experience any permanent benefit.   **Medically Futile** – Any treatments from which the patient almost certainly will not benefit.  **Most Responsible Provider (MRP)** – A physician, dentist, midwife or Nurse Practitioner who has the ultimate responsibility for that patient's care at HPHA.  **Resuscitation** – All medical interventions that are used in the event of an emergency where the patient has either no vital signs, or is in immediate danger of dying.  **Resuscitation Levels**   * Attempt Resuscitation -provide all interventions as required. CPR, defibrillation, cardioversion, intubation, mechanical ventilation (invasive and non-invasive). * Do Not Attempt Resuscitation (DNAR) – allow natural death if vital signs absent. NO CPR. NO DEFIBRILLATION. NO MECHANICAL VENTILATION.   **Standard of Care** – The degree of care which could reasonably be expected of a health practitioner who possesses and exercises the skill, knowledge and judgment of a normal, prudent practitioner of the same experience and standing, having regard to the resources and facilities available to health practitioners and patients. If the health practitioner holds him/herself out as a specialist, a higher degree of skill is required than of one who does not profess to be a specialist.  **Substitute Decision Maker (SDM)** – If patient is incapable with respect to a treatment, the *Health Care Consent Act* lists in order of rank the following deciders for the incapable person:   * Guardian of person with authority for treatment * Attorney named in Power of Attorney for Personal Care * Representative appointed by Consent and Capacity Board * Spouse or partner * Child or parent or Children’s Aid Society * Parent with right of access only * Brother or Sister * Any other relative by blood marriage or adoption * Office of the Public Guardian and Trustee   **NOTE**: the SDM is not necessarily the patient’s next of Kin.  **PROCEDURE**  1. Hospital Admission  The Most Responsible Provider (MRP) will discuss resuscitation/goals of care for every patient 50 years of age or older (and younger if clinically indicated) on every admission, regardless of resuscitation status on a previous admission, and complete a Resuscitation Status Order.  Patients in the Mental Health and Maternal Child units and those admitted for elective surgery are not mandated to have a Resuscitation Order Set completed unless co-morbidities indicative of a DNAR conversation are present.  Where the wishes of the patient are not able to be discussed or are not yet well understood, the MRP will document “Attempt Resuscitation” on the Physicians Orders sheet and revisit the resuscitation status at the earliest opportunity.  If a patient is admitted to hospital with a known wish (e.g. that they would not want resuscitation in a vital signs absent situation), but they are incapable and no SDM is available, the MRP will complete a Resuscitation Status Order consistent with prior wishes, and make attempts to speak with the SDM as soon as possible.  If the MRP determines that resuscitation should not be offered because it would fall outside the standard of medical care and/or treatment is felt to be medically futile, the MRP will inform the patient/SDM. Consent is not required prior to writing a DNAR order and physicians are only obliged to provide resuscitation when doing do is within the standard of care (Ontario Superior Court August 2019).   * If the patient/SDM is in agreement, the MRP will document DNAR as the resuscitation status on the Order Sheet, and that resuscitation is inappropriate as well as details of the discussion that took place with the patient/SDM. * Only if the patient or SDM disagrees upon learning that a DNAR order will be written must physicians engage in a conflict resolution process and find consensus. During this time, physicians must not write a DNAR order. However, if the patient’s condition deteriorates and they experience a cardiac or respiratory event while conflict resolution is underway, physicians are permitted to make a bedside determination regarding which resuscitative efforts, including CPR, to provide and are only required to provide those that are within the standard of care. ([CPSO guidelines](https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Car/Advice-to-the-Profession-Planning-for-and-Providin))   Where a patient has multiple transition points within a distinct HPHA site between “services” (e.g. acute, rehab, continuing complex care or mental health), the most recent printed Resuscitation Status Order Set is retained at the front of the chart and the transferring MRP will enter date and signature in the table on the Order Set to verify that there has been no change in the current Status. With the required discharge/admit processes between services, a Resuscitation Status order must be written and the Order Set scanned to Pharmacy. Transfers between HPHA sites require completion of a new Order Set.  2. Patients with “Do Not Attempt Resuscitation (DNAR)” Order undergoing an invasive procedure  The informed consent process for the proposed invasive procedure(s) for patients with a DNAR order will include a discussion regarding resuscitation including the implications for the resuscitation status during and immediately after the procedure.  If there is a DNAR order at the request of the patient/SDM, consideration should be given to whether the DNAR order should be suspended and for how long. The decision and discussion will be documented in the patient’s health record. If there is a significant change in resuscitation status following the invasive procedure, a new DNAR order will need to be completed with the patient/SDM.  3. Change in Patient’s Condition  Any time there is a change in the patient’s circumstances or condition which may have implications for resuscitation decisions, the MRP must:   * Review with the patient/SDM what was previously documented regarding resuscitation and the reason(s) for this decision. * Complete a new Resuscitation Status Order if the patient/SDM’s decision has changed. * Document the discussion with the patient/SDM.   A Consultant may create a new Resuscitation Status Order if they have followed the steps outlined in Section “Change in Patient’s Condition” and discussed with the MRP who concurs with the proposed changes.  4. Discharge  At time of discharge, patients who have DNAR indicated as their vital signs absent (VSA) code status will be given a Do Not Resuscitate Confirmation (DNR-C) Form (Appendix A), completed by the discharging physician, so that emergency services can honour the patient/SDM’s wishes in the community.  **Note: The MOHLTC’s DNR Confirmation form (Ontario Publication Number 4519-45 (07/10) is the only document paramedics can respect when it comes to DNRs.** The DNR Confirmation Form is not a DNR order, but rather confirms the existence of a duly filled and signed DNR order.  Discussion regarding resuscitation and orders will commence upon the next admission.  **Conflict Resolution Process**  HPHA recognizes its health care providers have no obligation to offer intervention/treatment (including resuscitative measures) that is medically futile and/or potentially harmful.  In the event that a patient/SDM requests treatment that is felt to be futile or harmful in the clinical judgment of the MRP, the steps outlined will be followed. Although the steps are presented in the order they will most likely occur, the order of the steps may vary and several steps may occur simultaneously. Discussion regarding each step will be documented in the progress notes. The process will convene as soon as any member of the health care team becomes aware of potential conflict and initiated irrespective of the condition of the patient.  The MRP will:   * Attempt to negotiate a plan that is acceptable to both the patient/SDM and the health care team. A summary of the plan and discussions pertaining to the plan will be documented. * Offer and arrange mediation with Ethicist – The Ethicist will meet with the patient/SDM and the health care team to attempt to mediate an agreement. * Offer a second opinion – The patient/SDM should be given an opportunity to request a second opinion, and be assisted by the health care team to obtain one. * Offer patient transfer/referral – The patient/SDM should be given an opportunity to request another provider to assume care of the patient. The health care team may transfer/refer care as necessary and possible. Transfer, if not contraindicated by the patient’s condition, must occur within a reasonable period of time. * Consider need for legal opinion.   Where physician has determined that resuscitation should not be offered, the patient/SDM will be informed that conflict resolution has been exhausted and the patient’s code status for VSA will indicate Do Not Attempt Resuscitation.  **REFERENCES**  HPHA Policies   * [HPHA Consent for Treatment policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=13230&lang=1)   Legislation   * [*Health Care Consent Act*](https://www.ontario.ca/laws/statute/96h02) * [*Substitute Decision’s Act*](https://www.ontario.ca/laws/statute/92s30)   Resources   * [College of Physicians and Surgeons of Ontario (CPSO) Policy # 6-16 Planning for and Providing Quality End-of-Life Care](https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Car/Advice-to-the-Profession-Planning-for-and-Providin)   APPENDIX  Appendix A –[Do Not Resuscitate Confirmation Form **Ontario Publication Number 4519-45 (07/10**](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45) |