| Manual | CLINICAL PRACTICE MANUAL | POLICY |
|---|---|---|
| Section | Planning & Providing Care | |
| **Title** | **Resuscitation** | |
| Prepared By | Interprofessional Practice | |
| Reviewed By | Collaborative Practice Council | |
| Approved By | MAC – September 2018 | Number: CPM-PPC-A-42.02 |
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**This policy applies to adult, inpatients only. Pediatrics and Obstetrics are NOT required to adhere to this policy**

**Bluewater Health recognizes that resuscitation decisions and discussions are essential to "good" patient care.**
**Bluewater Health recognizes its role in assuring that these discussions occur in a timely, sensitive "honest" manner**

Bluewater Health recognizes that these discussions and decisions can be very difficult for patients/Substitute Decision Makers (SDM), their families, and the health care team (HCT).

Patients have a right under the Health Care Consent Act (HCCA) to give or refuse consent to a proposed treatment (or, where the patient is incapable with respect to the decision, to have their SDM(s) give or refuse consent on their behalf).

Bluewater Health also recognizes its healthcare providers have no obligation to offer treatment (including resuscitative measures) where it is medically inappropriate, that is, it is almost certain not to benefit the patient (see Levels of Benefit) and/or is outside an accepted standard of care.

Bluewater Health recognizes that these principles can at times give rise to conflicting options, and is committed to ensuring there are appropriate processes in place to support patients and health care providers around resuscitation and life threatening situation including policies and procedures to ensure that:

- Resuscitation and life threatening situation discussions occur in a timely and sensitive manner;
- Medical Care Providers that are involved with these discussions are "skilled communicators" who are well informed of the patients' current medical condition and have knowledge of the proposed resuscitation treatments to appropriately counsel patients and/or their SDM.

- Decisions regarding the range of treatment options offered to a patient are consistent with the professional standards and expectations, as well as principles and obligations under the HCCA, where applicable;
- Patient rights under the HCCA are recognized and honoured;
- Discussions and decisions are appropriately documented and effectively communicated to the HCT
- MRPs/HCT and patients/SDMs are aware of and have timely access to mechanisms for resolving complaints, including the Hospital's conflict resolution process.

Bluewater health will differentiate between when the patient is in a vital signs absent situation or when the patient is in a life threatening situation.

**PROCEDURE**
**The Resuscitation Status Form (Appendix A) reflects 2 distinct clinical situations**
**Section 1: Cardiac arrest/vital signs absent, Section 1 is an expression of the patient's wishes. Section 1 may be asked by nursing.**

**Section 2: Treatments in the event of Life Threatening Situation. Section 2 is a plan of care and is to be completed by the MRP within 24 hours of admission if patient wishes a DNAR. MRP must be informed if patient wishes to be DNAR.**

## 1. Unplanned Hospital Admissions

1.1. The MRP/delegate will:

a) Consider the need for a resuscitation discussion for every patient and document on the Resuscitation Status form (RSF) as appropriate

b) Ask themselves of every patient at the time of admission the following questions:

*"Would I be surprised if the patient died over the next 12 months?"*
***AND/OR***
*"Would I be surprised if the patient developed a permanent loss of basic functional independence over the next 12 months?"*

Where the answer to either question above is **'NO'**, then the MRP/delegate has a responsibility to engage the patient, and/or the patient's SDM where applicable, in a dialogue about the patients' resuscitation status in light of their current medical condition.

Where a resuscitation conversation takes place, the details of the conversation will be documented in the health record progress notes as soon as possible after discussion takes place.

Where the MRP (or delegate) is uncertain of how to answer the above questions because the condition of the patient is not yet well understood, document on the Resuscitation Status form that in the event the patient is found Vital Signs Absent (VSA), resuscitation will be attempted, as per default and the patient/SDM should be informed of this. The MRP/delegate will revisit the Resuscitation Status form after 48 hours to determine if a resuscitation conversation is warranted.
<u>*Exception*</u>: If a patient is admitted to hospital with a known wish that they would not want resuscitation in a vital signs absent situation, but they are incapable AND no SDM is available, indicate DNAR is based on prior wishes where SDM is unavailable and make attempts to speak with SDM as soon as possible.

Where the answer to both questions above is ‘YES’, the MRP/delegate will document “Attempt Resuscitation” (AR), indicate that this is the default position, and sign the Resuscitation Status form.

c) Consider the need for a conversation to address Life-Threatening Situation:

In any circumstance where instructions are Do Not Attempt Resuscitate (DNAR) for VSA, the MRP/delegate will have a discussion with the patient/SDM about an appropriate resuscitation plan for life threatening situations. For these patients, the ‘Life-Threatening Situation’ instructions on the Resuscitation Status form will be filled out by the MRP/delegate.

1.2. If there is an existing RSF in the patient’s health record (i.e. from a previous admission) the MRP/delegate will:

a) Assess whether there has been a change in the patient’s circumstances and /or condition which may influence previous resuscitation decision-making.
b) Review with the patient/SDM what was previously documented regarding resuscitation and the reason(s) for this decision.
c) Complete a new RSF in light of the patient’s current status, even if there are no changes from the last documented admission.
d) Document the discussion with the patient/SDM in the health record progress notes.

1.3. If the MRP/delegate determines that resuscitation should not be offered because it would fall outside the standard of medical care, or because the patient almost certainly will not benefit the MRP/delegate will:

a) Explain his/her reasoning to the patient/SDM.

If the patient/SDM does not object, the MRP/delegate will document code status on the Resuscitation Status form, that resuscitation is inappropriate, and that a conversation about code status took place.

If the patient/SDM disagrees with the MRP/delegate and insists on an ‘Attempt Resuscitation’ status, the MRP/delegate will

Document ‘Attempt Resuscitation’ on the Resuscitation Status form and that Patient and/or SDM has been informed and conflict resolution measures have been initiated

Initiate conflict resolution procedures

## 2. Planned Hospital Admissions

2.1. When obtaining consent for a procedure that will be performed as part of a planned hospital admission the MRP/delegate will:

a) Follow the procedures identified in section 1 above.

## 3. Patients with DNAR order undergoing an invasive procedure

3.1. 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.

3.2. 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 rationale will be documented in health record progress notes along with applicable time period. A new Resuscitation Status form will be completed by the physician obtaining consent for the invasive procedure and indicating that the code status is temporary.

**For Example:**

a. **If** the patient recovers in the Post Anesthetic Care Unit (PACU):

   **Then** a discussion between the MRP and patient/SDM should take place as soon as possible to determine when it is appropriate to reinstate DNAR.

b. **If** the procedure is done at the bedside (e.g. thoracentesis) or the patient returns to their bed immediately after the procedure (e.g. endoscopy):

   **Then** reinstitute DNAR as soon as the procedure is completed and related complications are unlikely to occur.

c. **If** the patient recovers in the critical care unit:

   **Then**, a discussion with the intensivist, surgeon, and SDM will take place soon as possible to determine when it is appropriate to reinstitute DNAR

## 4. Revision

4.1. Any time there is a change in the patient’s circumstances or condition which may have implications for resuscitation decisions, the MRP/delegate must review and repeat Steps 1.2 to 1.3

4.2. Where AR is temporary, or where DNAR was result of prior wishes and no available SDM, MRP or delegate must explore the earliest possible opportunity to revisit Steps 1.2 to 1.3

4.3. A Consultant or Consulting Service may make changes to the Resuscitation Status form if they have spoken with the MRP who agrees with the proposed changes. Steps 1.2 to 1.3 must also be followed.

4.4. If a Patient is transferred from one care area to another and a new chart is required, a new discussion regarding resuscitation status may not be required if the MRP is already familiar with the patient’s wishes. A new code sheet should be placed on the patient chart in the absence of any previous one.

## 5. Identification

5.1 Identifying the patient’s wishes

**Arm Band** – Upon completion of section 1 of the Resuscitation Status Form, the primary nurse will apply a blue band to patients identified as any level other than a level 1 (full code) on initial assessment and notify the MRP.

## DEFINITIONS

**Basic Functional Independence:** The 6-item activities of daily living instrument can be used to quantify dependencies in basic functioning (bathing, dressing, feeding, transferring from bed to chair, bladder and bowel control, and use of the toilet).

**Delegate:** Physician or Nurse Practitioner

**Health Care Team:** The health care professionals providing care to the patient (e.g. physicians, nurses, allied health professionals).

**Levels of Benefit:** There are 3 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's 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 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 Inappropriate Care:** Any treatments in which the **patient almost certainly will not benefit**, and/or any treatments that falls outside an accepted **standard of care**.

**Most Responsible Provider (MRP):** A physician, dentist or midwife who has the ultimate responsibility for that patient's care at Bluewater Health.

**Resuscitation:** Resuscitation describes 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 Level in event of life threatening situation

**Level 1 - FULL RESUSCITATION**: Use intubation and invasive mechanical ventilation as indicated. Provide advanced resuscitation including life support measures available in the intensive care unit. May use vasoactive drugs, cardioversion and cardiac monitor to support heart function. Bipap, Hi flow O2,

**Level 2 - ADVANCED LIFE SUSTAINING THERAPIES**: May use vasoactive drugs, cardioversion and cardiac monitor to support heart function. May consider non-invasive mechanical ventilation to support breathing, Bipap, Hi flow O2, Consider intubation, suitable for high intensive care unit.

**Level 3 – MEDICAL TREATMENT**: In addition to care described –below may use medical treatment, antibiotics, and IV fluids as indicated to manage reversible problems, if they are expected to return patient to previous state of health. No intubation, No mechanical ventilation (invasive or non-invasive) No vasoactive drugs. Not suitable for intensive care unit.

**Level 4 – COMFORT CARE;** Maximize comfort through symptom management including analgesics and/or sedatives to relieve pain, dyspnea/agitation, and other measures to provide comfort, and allowing natural death. No intubation, No mechanical ventilation (invasive or non-invasive) and No vasoactive drugs.

**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):** refer to Consent to Treatment Policy.

## REFERENCES

### Corporate Policies
Escalation of concerns
Consent to Treatment

### Legislation
Health Care Consent Act
Substitute Decision's Act

### Other References
CNO Guiding Decisions on End of Life Care Practice Guideline, 2009
College of Physicians and Surgeons of Ontario Policy Statement #1-06 Decision-making for the End of Life

## APPENDICES

### Appendix A

**Appendix A**

# Resuscitation Status Form

## Section 1 - IF VITAL SIGNS ARE ABSENT
**Expression of patient's wishes on admission**

| ☐ Attempt Resuscitation | ☐ Do Not Attempt Resuscitation |
|---|---|
| Full cardiopulmonary resuscitation and intubation with mechanical ventilation | No cardiopulmonary resuscitation<br><br>If Pt wishes to be DNAR, MRP must be informed and section 2 MUST be completed by MRP |

## Section 2 – IF LIFE-THREATENING SITUATION
**Plan of Care - To be completed by MRP or delegate within 24 hours of Admission**

**If Pt wishes to Attempt full resuscitation in section 1, they are a level 1 in Section 2**

*If specific ICU Treatments are not acceptable to patients in Level 2, please cross out.

| ☐ LEVEL 1<br><br>FULL RESUSCITATION | ☐ LEVEL 2<br><br>ADVANCED LIFE SUSTAINING THERAPIES | ☐ LEVEL 3<br><br>MEDICAL TREATMENT | ☐ LEVEL 4<br><br>COMFORT CARE |
|---|---|---|---|
| **Yes to CPR**<br>**Yes to Defibrillation** | **No** CPR<br>**No** Defibrillation | **No** CPR<br>**No** Defibrillation | **No** CPR<br>**No** Defibrillation |
| **Yes to Intubation** | Intubation<br>○ Yes<br>○ No | **No** Intubation | **No** Intubation |
| **Yes to ICU Treatments:**<br>Cardioversion<br>Bipap<br>Hi flow O2<br>Vasoactive medications | **Yes to ICU Treatments***:<br>Cardioversion<br>Bipap<br>Hi flow O2<br>Vasoactive medications | **No** ICU<br><br>**Focus on ACTIVE Medical Treatment** | **No** ICU Treatments<br><br>**Focus on COMFORT Measure Treatments**<br><br>Consider Palliative Care Consult |
| **Suitable for ICU Admission** | | **Not Suitable for ICU Admission** | |

**COMMENTS:** ________________________________________________

________________________________________________

________________________________________________

________________________________________________

**SIGNATURE:** ______________________________ **DATE:** ______________________________

*Change of status requires new Resuscitation Status Form (Line through previous Resuscitation Status Form)*



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