Resuscitation Level

Signing Authority:	Chief of Staff and Chief Nursing Executive		
Approval Date:	06-01-2016	Effective Date:	30-03-2016

SCOPE:

This policy and procedure applies to Resuscitation Level designations that guide the agreed upon use of health interventions in order to benefit a person, in accordance with that person's values and aims, and in relation to achievable, intended health outcomes.

Resuscitation Level designations reflect the practice environment, and provides direction to staff regarding specific interventions and limitations on interventions as established after consultation between designated Healthcare Professionals and patient/substitute decision maker (SDM).

POLICY STATEMENT:

Resuscitation Level designations guide the patient/SDM and healthcare providers about the decisions that have been agreed upon regarding the intention of care. The designations enable health care teams to provide timely care that is both medically appropriate and meets the patient's values and wishes.
This policy is mandatory for admitted adult patients. For paediatric, obstetric, and all outpatient visits; when the clinical situation dictates and at the discretion of the Most Responsible Provider (MRP), a resuscitation level of minimally invasive, supportive or comfort care will be available to the patient and their families.

DEFINITIONS:

For the purposes of this policy and Appendix

Advance Care Planning is a process by which people think about their values regarding future healthcare choices; explore medical information that is relevant to their health concerns; communicate wishes and values to their loved ones, their SDMs and their healthcare team; and record those choices.

Advance Directive is a written document that enables individuals to give direction and clarification to health care professionals and other service providers. An Advanced Directive has effect only when the maker of the Advanced Directive is not able to express his/her wishes and/or has been deemed incapable. The document serves as a guide to help decision-making.

The terms "Advance Directive and "Living Will" are often used interchangeably.

Advanced Pharmacological Treatments means drug therapies that include but are not limited to inotropes, vasopressors, etc.

Capacity means the ability to understand the information that is relevant to the making of a personal decision, and the ability to appreciate the reasonably foreseeable consequences of a decision or not making a decision.

Home Care means care provided in a person's home by a family member, privately hired professionals, and/or through a community based service like the Region's Supported Living Program, Community Care Access Centre etc.

Hospice Care means care provided in a hospice through the Region's Hospice Palliative Care Service.

Intensive Care means advanced and highly specialized care provided to patients whose conditions are life-threatening and require comprehensive care and constant monitoring, usually administered in specially equipped units of a health care facility (National Library of Medicine, 1992).

Living Will is a document in which a person writes down what they want to happen if they become ill and are not able to communicate their wishes about treatment. This document is not a legal document nor is it binding.

Non-Invasive Positive Pressure Ventilation (NiPPV) means mechanical ventilation using positive pressure with a tight fitting mask; may include continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP).

Ontario Public Guardian and Trustee (OPGT) is part of Ontario's Ministry of the Attorney General delivering services that safeguard the legal, personal and financial interests of individuals and estates. The OPGT plays a role in searching for heirs for estates.

Patient means an individual receiving health care and/or services at the Royal Victoria Regional Health Centre (RVH) as defined in this policy. The term "patient" shall also be interpreted to mean: **"Client"** within Long-term Care (LTC) and Community Care Access Centre (CCAC) and the patient's SDM, as appropriate.

Power of Attorney is a legal document in which a person names a specific individual to act on his/her behalf.

Resuscitation means measures undertaken to reverse and stabilize an acute physiological derangement. This may include, but is not limited to, chest compressions for pulselessness, as well as ventilatory support and medication in an attempt to regain homeostasis.

Resuscitation Level means the agreed upon use of health interventions in order to benefit a person, in accordance with that person's values and goals of care, and in relation to achievable, intended health aims. Resuscitation Level designation reflect the practice environment, and specifically, provide direction to staff regarding specific interventions, transfer decisions, locations of care, and limitations on interventions as established after consultation between designated Healthcare Professional and patient.

Substitute Decision Maker (SDM) means a person, who has authority to make decisions on behalf of another person, including a member of the patient's family, a parent who has legal guardianship of a minor child not deemed a "mature minor", a person appointed as a legal SDM/guardian by a court of competent jurisdiction, or a person designated as an agent in an Advanced Directive. This should be clearly identified in the chart. See Appendix E for list of hierarchy.

Workers: A collective term referring to all RVH employees as well as professional staff with RVH privileges (i.e., medical, dental, midwifery, and extended class nursing staff), volunteers, students, and contractors, as applicable. The term applies whether working on RVH property or working on behalf of or representing RVH elsewhere.

PROCEDURE:

1. Resuscitation Level

There are two primary roles for the Resuscitation Level:

(a) To serve as a communication tool for healthcare professionals to assist in rapid decision making in times of crisis; and

(b) To guide healthcare professionals and patients regarding the general intentions of the care and interventions that are to be provided. While a designation order is prescriptive under most circumstances, if new circumstances or health issues arise, it is crucial that the Resuscitation Level designation be reviewed in order to validate its sustained relevance.

2. Resuscitation Level Designations

Resuscitation Level designations are to be used within the hospital and will go with the patient on transfer between sites. Detailed descriptions of the Resuscitation Level designations, and important clinical features embedded in them, can be viewed in Appendix 'A'.

3. Resuscitation Level Conversations

3.1 Resuscitation Level conversations and documentation will take place upon inpatient admission or within 24 hours in a patient's course of care and/or treatment. For the outpatient settings this will occur at the discretion of the MRP when clinically relevant. These discussions explore patients' wishes and goals for treatment framed within the therapeutic options that are appropriate for their condition. An Advanced Directive may exist and a reasonable effort will be made to obtain this directive in order to inform conversations regarding Resuscitation Level.

3.2 Conversations about Resuscitation Level are undertaken with the patient, or, if the patient lacks capacity to make such decisions, with the patient's SDM.

The Substitute Decision Makers Hierarchy:

a) Guardian appointed by the court if the court order authorizes the guardian to make health care decisions

b) Person with a "power of attorney for personal care" authorizing him/her to make health care decision

c) A representative appointed by the Consent and Capacity Board

d) The incapable person's spouse or partner.

e) A child or parent of the incapable person, or a Children's Aid Society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent.

f) A parent of the incapable person who has only a right of access.

g) A brother or sister of the incapable person.

h) Any other relative of the incapable person.

i) The Ontario Public Guardian and Trustee

If the patient's SDM cannot be contacted, or, if is not known, conversations may include close friends and informal caregivers who are known to be significant and are known to be acting in the best interest of the patient.

3.3 Any member of a patient's healthcare team may initiate and undertake a Resuscitation Level conversation. The MRP, however, is ultimately responsible for the discussion and the order reflecting the Resuscitation Level designations. In collaboration with other members of the healthcare team, the MRP (or designate) will ensure that Resuscitation Level designations discussions/documentation include:

- the patient's prognosis, Resuscitation Level designations and anticipated outcomes of current treatment;
- exploration of the patient's or SDM's understanding of the hopes/wishes for outcomes of treatment;
- the role of Life Support Interventions and their expected Degree of Benefit;
- the wishes of the patient with respect to organ and tissue donation;
- information regarding the provision of comfort measures;
- an offer for involvement of hospital resources such as the palliative care program, social work, clinical ethics consultation, or spiritual care to assist the patient with his/her needs; and
- documentation of pertinent details of this communication in the patient's health record.

3.4 In a time-sensitive health crisis, if there are no expressed wishes by the patient with regard to Resuscitation Level designations, the MRP, in consultation with members of the health care team, shall assess the potential benefits and harms of life support interventions and initiate the most clinically relevant Resuscitation Level designation Order.

3.5 In the event that the attending MRP is not available to provide an Order for intervention or withholding of intervention during a time-sensitive health crisis, the patient will receive available life support interventions.

3.6. Attempts to reconcile any disagreement regarding the Resuscitation Level designations order will follow the consensus building process set out in Section 8 of this policy.

4. Advanced Directive

4.1 Where a patient's Advance Directive/Power of Attorney is known to exist, staff will make reasonable effort to obtain a copy for placement in the front of health record.

4.2 During care provision, the MRP (or designate) will be notified of the following, when clinically relevant:

- when a patient makes a request limiting Life Support Interventions; or
- when an Advanced Directive stipulates that the patient requests limits to Life Support Interventions.

4.3 In the circumstance that a known Advanced Directive or Living Will includes a limit on care and treatment, it is the MRP's duty to promptly review these with the patient/SDM then translate into an appropriate Resuscitation Level Designation Order. If a Resuscitation Level Designation Order is not available, the requests to limit care and treatment as outlined in an Advanced Directive, or which have been expressed by the patient, will be followed, notwithstanding the provisions included in 4.4 below.

4.4 Where the provisions of an Advanced Directive or a patient expressly request interventions that certainly will not benefit, those interventions are not provided (See also Consensus Building) and the reasoning reviewed with the patient/SDM.

5. Documentation of the Resuscitation Level Designation

5.1 A Resuscitation Level Designation pre-printed order form will be filled out by the MRP within 24 hours of admission and documented in the patient's electronic health record. The conversation about the Resuscitation Level designation and goals of care held with the patient/SDM will be clearly documented in the health record.

5.2 The Resuscitation Level Designation Order will be placed on the patient's electronic health record under the Advanced Directives section.

6. Resuscitation Level Designation across the Continuum of Care

6.1 Resuscitation during surgery or in the recovery room will be performed, including short term physiologic and mechanical support, in order to return the Patient to prior level of function. The possibility of intra-operative death or life threatening deterioration should be discussed with the patient in advance of the proposed surgery and general decision making guidance agreed upon.

6.2 When a patient is transferred from one site or institution, the Resuscitation Level Designation Order will be part of the discharge orders.

7. Review of Resuscitation Level Designation Orders

7.1 A patient's Resuscitation Level Designation will be reviewed if there is a significant change in the patient's condition that may be relevant to Resuscitation Level, or at the request of the patient/SDM.

7.2 Discussion with the patient/SDM for review and renewal of the Resuscitation Level Designation Order is based on clinical judgment of the MRP. A change in the Designation Order will be discussed with the patient/SDM and documented.

8. Resuscitation Level Designation Decision Support and Consensus Building

In the event that there is uncertainty, distress, sudden change in patient's or disagreement regarding the appropriateness of life support interventions, or the Resuscitation Level Designations, whether between the patient/SDM and MRP, or the patient /SDM and members of the health care team, or among the members of the patient's health care team; the following steps should be followed (Appendix D):

8.1 Second Opinion
If the patient/SDM does not accept a plan of treatment and/or the Resuscitation Level Designation, a second opinion from another physician will be obtained.

8.2 Hospital Support
Members of a patient's healthcare team and the patient/SDM have access to hospital resources to assist in decision-making; these include the palliative care program, social work, clinical ethics consultation/board support, or spiritual care to assist the patient/SDM with his/her needs. If patient/SDM seeks assistance accessing such resources, access must be facilitated.

8.3 Consent Capacity Board
Consult can be obtained by Consent and Capacity Review Board as deemed appropriate for dispute resolution. The MRP (or designate) shall ensure the patient/SDM is informed of, and has access to, the avenues of decision support and dispute resolution process.

9. Implantable Cardioverter Defibrillators

Patients with Implantable Cardioverter Defibrillators (ICD) may require disabling of the anti-dysrhythmia functions (ramp pacing and/or defibrillation) in order to align with the patient's goals of care and Level of Resuscitation wishes. This is to prevent painful and

unnecessary shocks in the end-of-life period. The MRP should be made aware of any patient with an ICD so this discussion can be had with the patient. Arrangements can then be made with the cardiac technologists to appropriately change the programming of the ICD. If possible, to support the transition back to the community this is to be completed prior to transfer to hospice or home.

9.1 In the case of an emergency situation where the anti-dysrhythmia functions of the ICD need to be disabled in the end-of-life period, a cardiac magnet can be applied by the physician over the chest by an appropriately trained health care professional. This will prevent painful shocks, while maintaining pacing capacity.

CROSS REFERENCES:

Consent to Treatment (June 2014)

REFERENCES:

- American Society of Anesthesiologists – Perioperative Do-Not-Resuscitate Orders
- Guiding Decisions about End-of-life Care, CNO, 2015
- Joint Statement on Resuscitative Interventions (Update 1995), Canadian Medical Association
- Ontario's Health Care Consent Act (HCCA) (1996)
- Healthcare Quarterly A Checklist for End of Life, 2014, Vol. 14 No.4
- Making Substitute Health Care Decisions: The Role of the Public Guardian and Trustee, Office of the Public Guardian and Trustee Website
- Perioperative Do-Not-Resuscitate Orders. American Society of Anesthesiologists Newsletter. March 1, 2014
- Peri-operative Status of "Do Not Resuscitate" Orders and Other Directives regarding Treatment, CAS Committee on Ethics, Guidelines to Practice of Anesthesia, 2002 www.cas.ca/English/Page/Files/97_ethics.pdf
- Powers of Attorney and "Living Wills", Office of the Public Guardian and Trustee

APPENDICES

Appendix "A" Resuscitation Level Designation Form
Appendix "B" Checklist for Resuscitation Designation Discussions
Appendix "C" Electronic Order Entry
Appendix "D" Model for Consensus Building
Appendix "E" Substitute Decision Maker Hierarchy

RVH Royal Victoria Regional Health Centre

RESUSCITATION LEVEL DESIGNATION ORDER FORM

PATIENT NAME: _____

DOB: _____

HRN: _____

(addressograph)

Discussed with Patient or Substitute Decision Maker (SDM): ☐ **YES** ☐ **NO**

LIFE THREATENING SITUATION		VITAL SIGNS ABSENT	
(CHECK ONLY ONE)	**DESCRIPTION**	**BEGIN CARDIOPULOMNARY RESUSCITATION (CPR) AND ATTEMPT RESUSCITATION:**	
INVASIVE* ☐	Full resuscitative care including intubation and mechanical ventilation, invasive monitoring and advanced pharmacological treatments (inotropes, vasopressors etc.) *May be managed in Intensive Care Unit (ICU) or other monitored unit.*	**YES*** ☐	**NO** ☐
MINIMALLY INVASIVE ☐	May include Non-Invasive Positive Pressure Ventilation (NIPPV), (Bi-level Positive Airway Pressure [BIPAP], Continuous Positive Airway Pressure [CPAP]), cardiac pacemakers, and advanced pharmacological therapies (inotropes, vasopressors etc.) No intubation or defibrillation, including implanted cardiac defibrillators. *May be managed in ICU or other monitored unit.*	**NO Allow Natural Death**	
SUPPORTIVE ☐	Medical treatment including, but not limited to, antibiotics, IV fluid resuscitation, etc. No mechanical ventilation or NIPPV No advanced pharmacological treatments (inotropes, vasopressors etc.) *Managed outside ICU*	**NO Allow Natural Death**	
COMFORT ☐	Focus is on comprehensive, compassionate, comfort care for patient and family. *Managed in hospital outside ICU, Hospice or Home*	**NO Allow Natural Death**	

☐ Based on discussion with capable patient

☐ Based on discussion with SDM - Name: _____ Relation to Patient: _____

☐ Based on documented previous wishes when unable to discuss with patient and SDM not available

☐ Based on MRP determination of benefit of treatment (conflict resolution measures in process).

Patient remains INVASIVE level of RESUSCITATION + CPR until conflicted resolution measures completed

*If discussion with patient not possible, previous documented wished are unknown, and SDM not available, default resuscitation level is RESUSCITATION + CPR if vital signs absent.

Most Responsible Provider (MRP): _____ Date: _____

Transcribed by: _____ Date: _____

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Appendix B - Checklist

In order to meet one's ethical and legal obligation at the end of life and minimize errors the following checklist may be used.

Benefits of using a checklist:

- Minimizes common errors at the end of life
- Ensures patient centered decision-making by respecting wishes and values
- Respects professional integrity and clinical judgment
- Ensure that the team meets ethical and legal obligations to patients
- Clarifies what constitutes an end-of-life conversation

Examples of 'error' at end of life

- Not acting on applicable wishes of patients made when they were capable
- Not identifying who the legal substitute decision-makers are
- Not explaining the consequences of the treatment alternatives, resulting in unrealistic expectations
- Allowing family members or SDMs to 'direct' care, resulting in treatments that are not indicated

CHECKLIST

Step	Dialogue and Documentation
1. Ask the capable patient about wishes and beliefs.	a. "What is your understanding of your condition?" b. "What worries you about your situation?" c. "How do you make decisions in your family?" d. "What is important to you right now when making decisions?" e. "If the patient is not capable, document this before proceeding
2. Identify the legally correct SDM	a. See hierarchy of decision- makers (section 3.2) b. Document decision-maker(s) c. Ask for proof and place a copy on the chart.

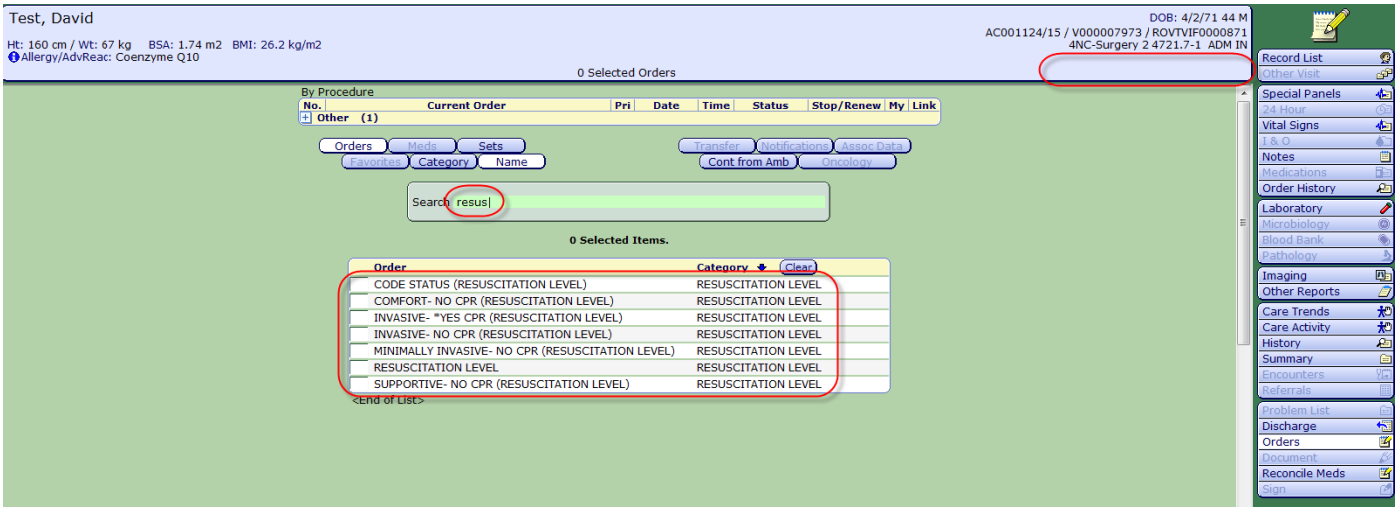
3. Ask questions of the SDM	a. "Is there a living will?" b. "Do you know your role?" (e.g. to act on prior expressed wishes or best interests of the patient)? c. "Do you know what the patient would have wanted in this situation and what was important to this person?" (share beliefs or stories) d. Document what you learn
4. If there is no prior applicable wish, inform the SDM about "best interests"	If there are no prior expressed wishes, we then have to consider what is in the best interest of the patient – this means we can propose treatments that will change or improve the condition of the patient for the better, while taking into account this individual's goals, values and beliefs.
5. Propose an indicated treatment plan	a. "We are going to do what will benefit your loved one and we will continue the treatments that are indicated and in <his/her> best interests," OR b. "<patient's name> is really sick. We will provide treatment that improves or changes <his/Her> condition for the better, so that leaves us with the following options: comfort care etc..." c. "When a treatment is no longer indicated, we will let you know that we are no longer providing it."

6. If NO consent is obtained, state the following.	a. "It is a challenge when we cannot reach agreement; however, we have a few resources that can help us: i. We can obtain a second opinion, or, (see section 8). ii. We can ask for a consult from our internal Ethics Committee, or, iii. We can call the Consent and Capacity Board (CCB) which acts as a neutral third party that will come into the hospital and listen to both sides of the story. The board will then decide what is in the best interest of the patient. The patient would be appointed a lawyer, and the physician may have a lawyer as well. You personally are entitled to have one also (refer to www.ccboard.on.ca). b. Document that you have explained the role of CCB. Give the family time to ask questions

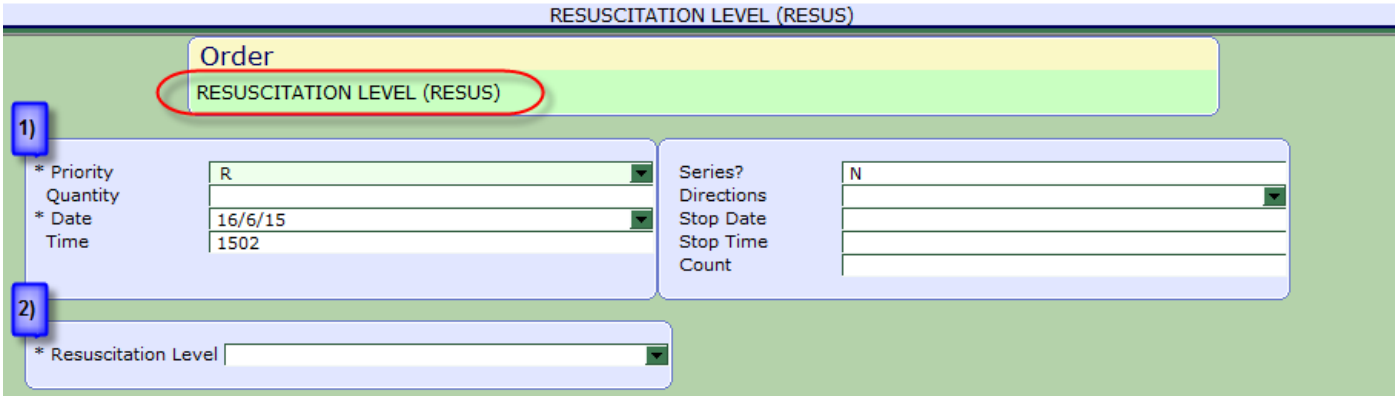
MEDITECH POM ordering System (Appendix C)

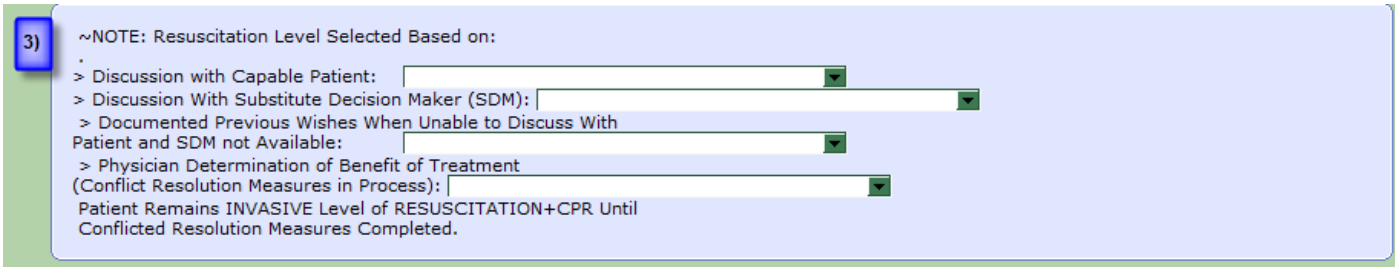
Resuscitation Level Order:

Searching for the order: Enter "Resus" or any form of the words resuscitation, code status, comfort, supportive, invasive- YES CPR and Invasive – NO CPR (these choices will bring the user to the Resuscitation order.)
Note that the patient doesn't have any code entry in the top right corner of the patient header. (all new registrations will display like this)



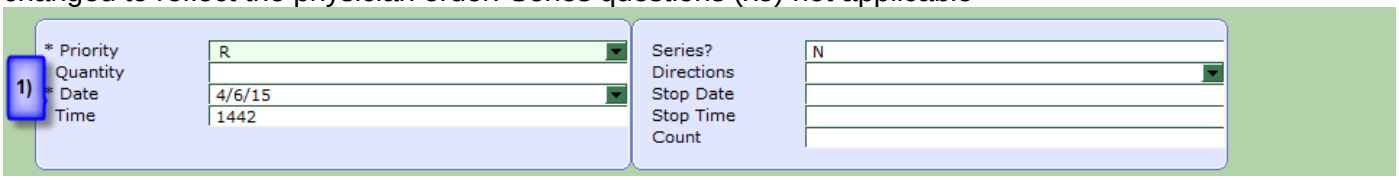
Resuscitation Level Order:



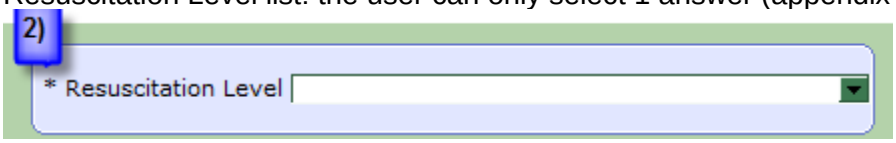


Sections of the Order

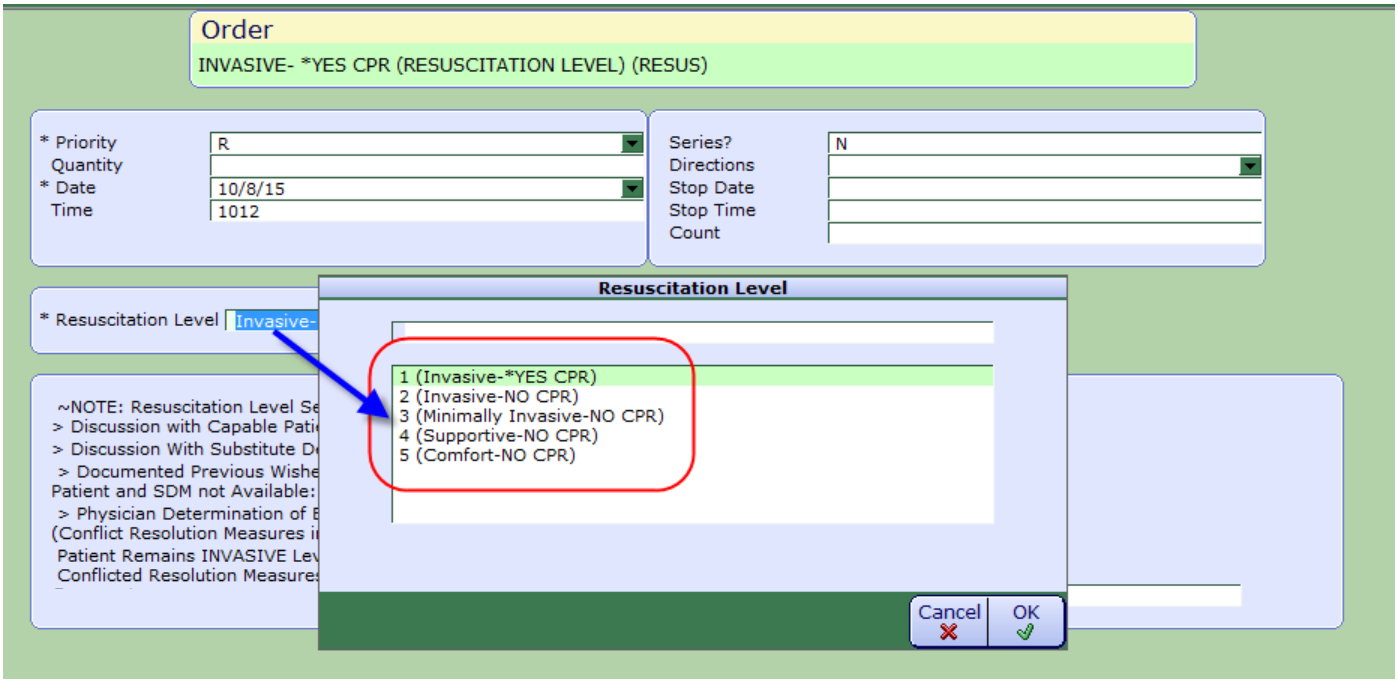
1) Resuscitation Priority, Date and Time. The default setting is Routine, Today and now. These can be changed to reflect the physician order. Series questions (x5) not applicable



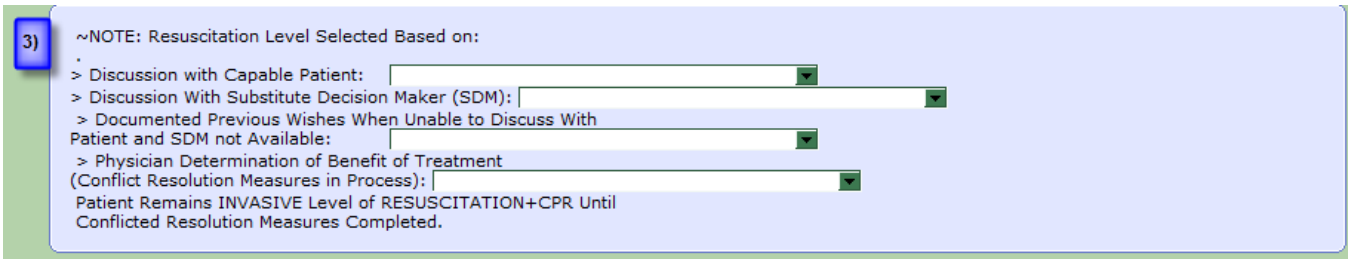
2) Resuscitation Level list: the user can only select 1 answer (appendix A)



Resuscitation Level List (based on appendix A):

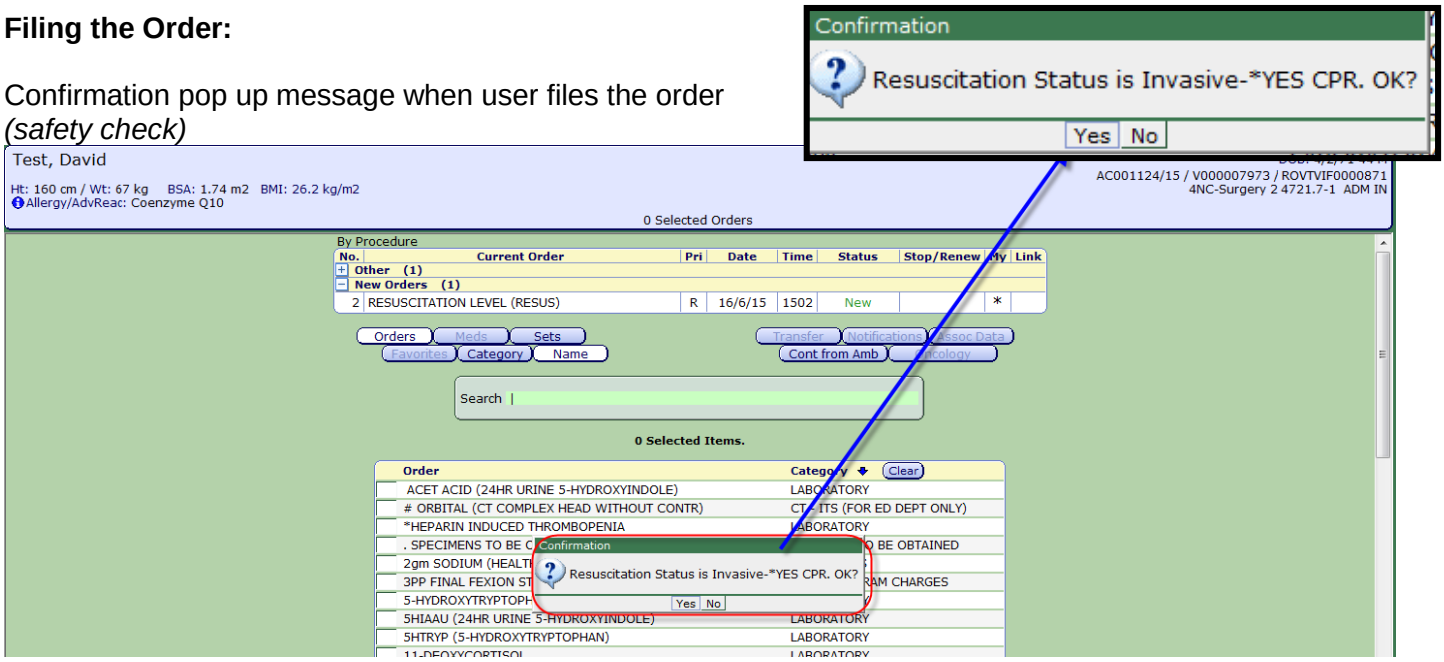


3) Additional Information fields: Yes only questions that will need to be entered based on Order.

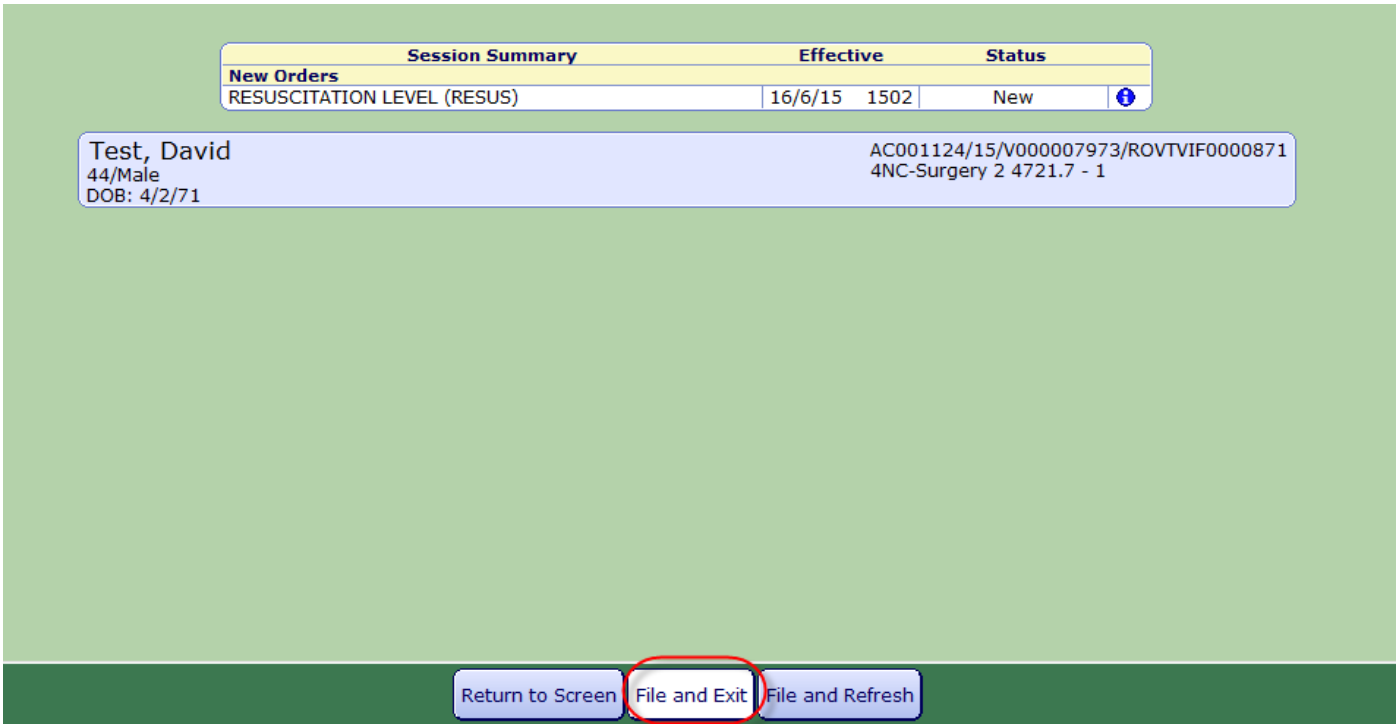


Filing the Order:

Confirmation pop up message when user files the order *(safety check)*

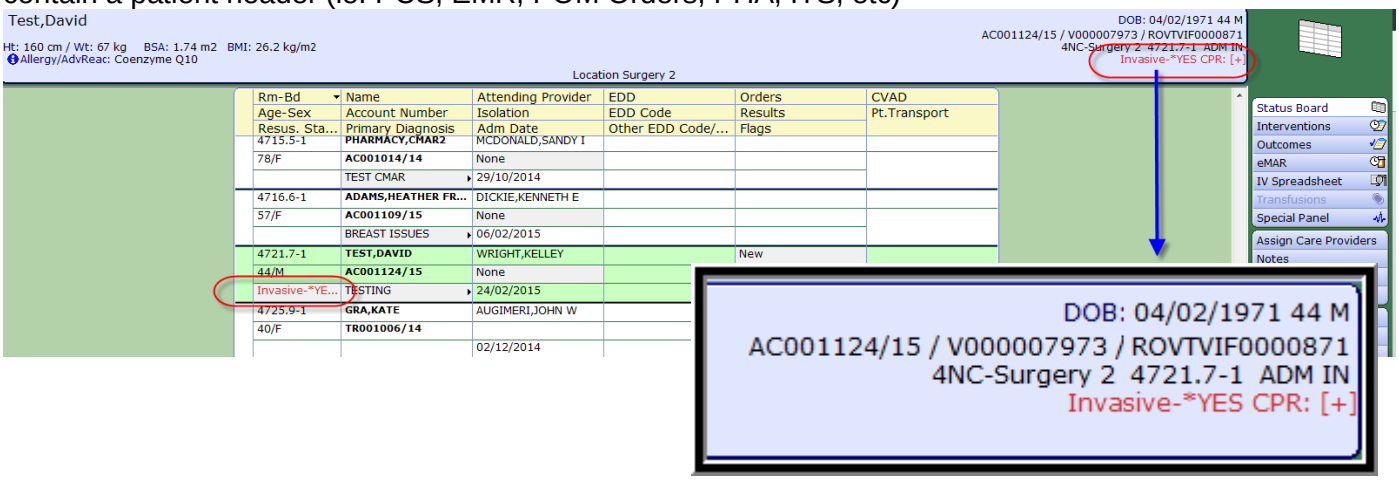


Confirmation screen and then FILE and Exit Orders screen (POM)

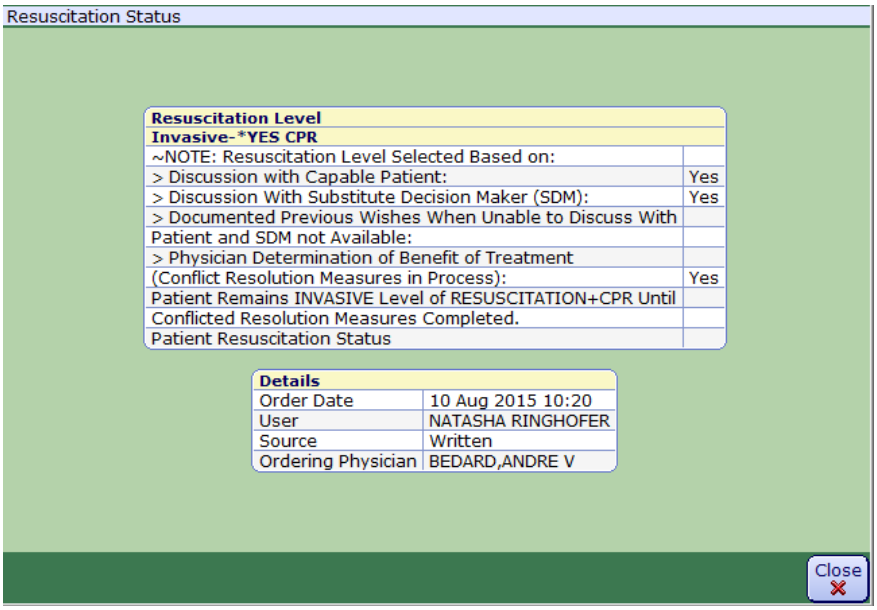


Where does the Resuscitation Level display in MEDITECH?

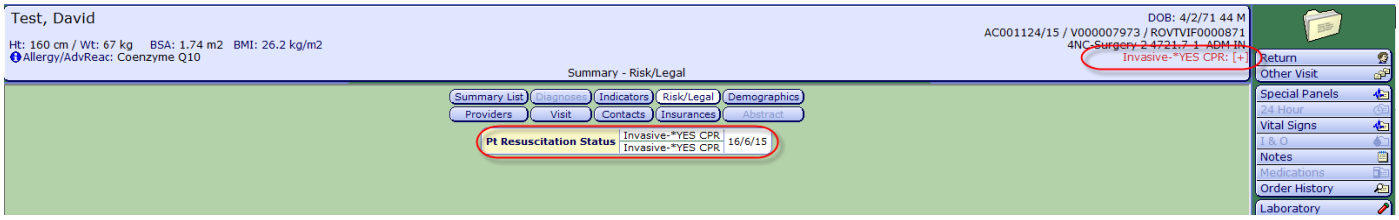
Patient Header and status boards display Resuscitation Level status in all modular applications that contain a patient header (ie. PCS, EMR, POM Orders, PHA, ITS, etc)



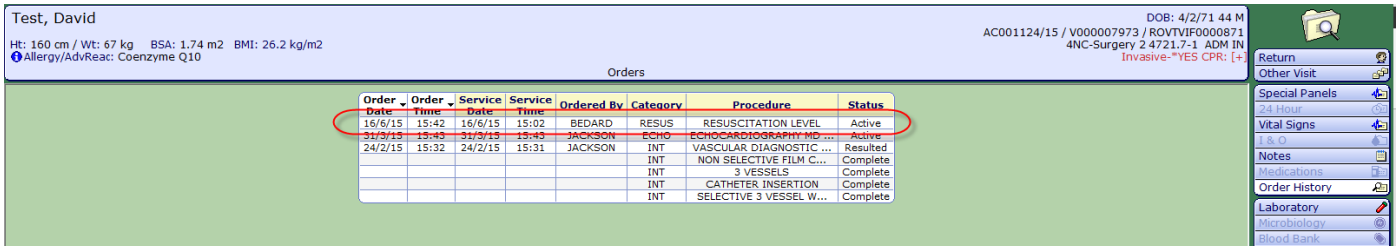
When **[+]** is selected order details display



EMR View in Summary Panel (Risk/Legal) also displays the history of Resuscitation orders.

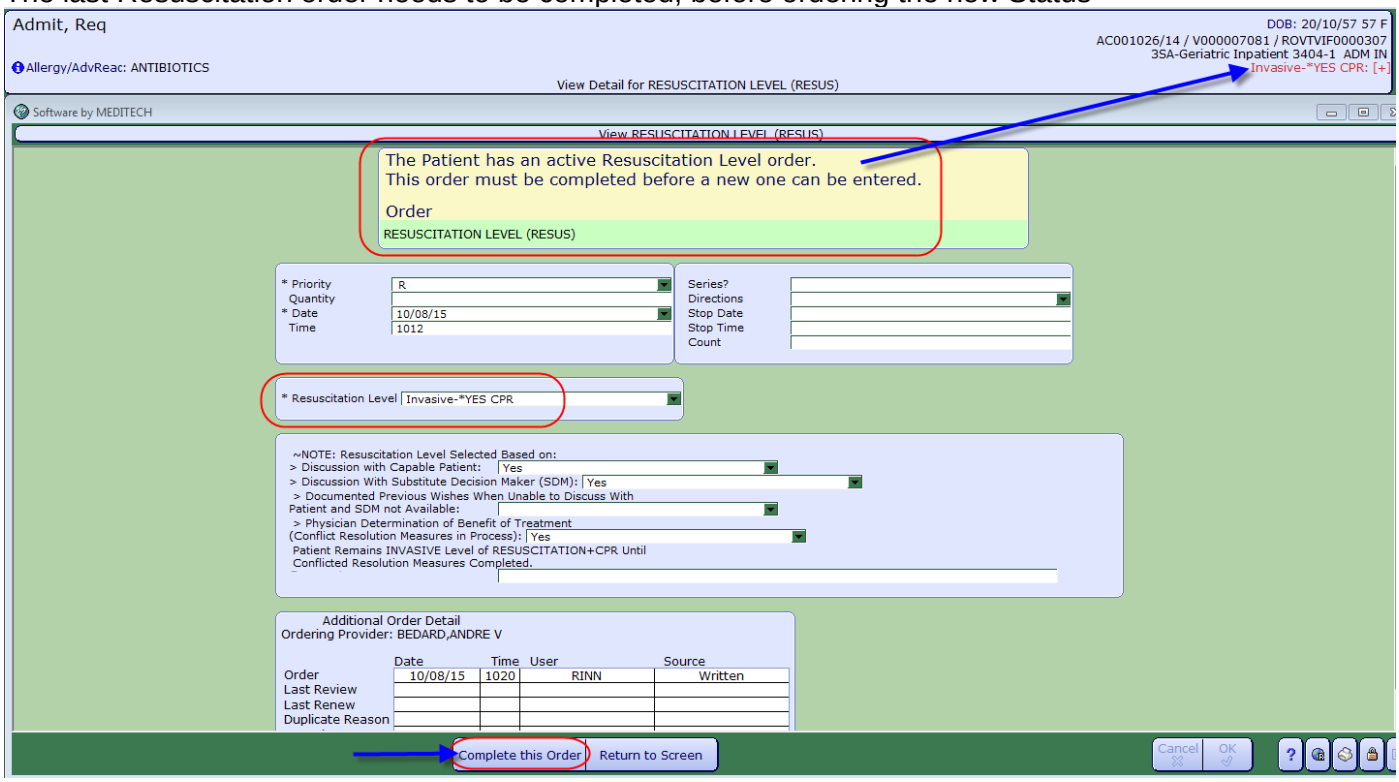


EMR View in Order History Panel

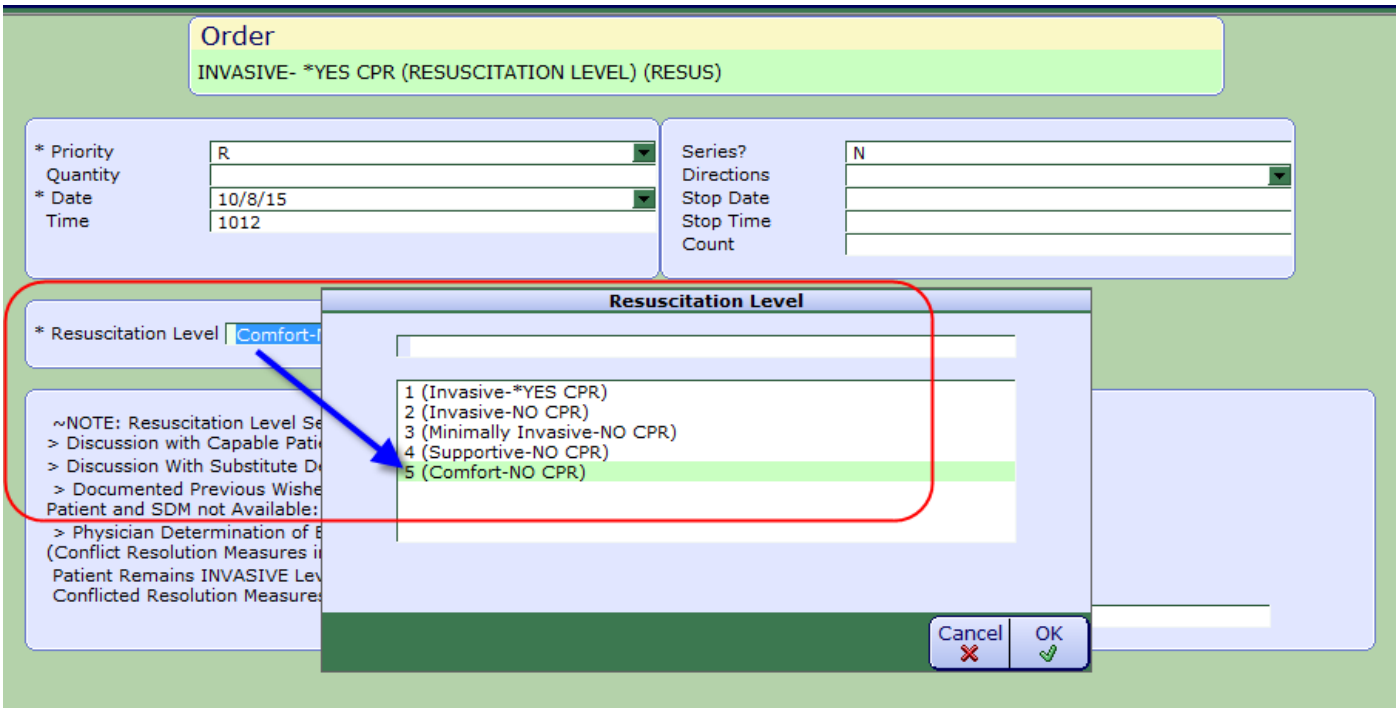


Changing a Resuscitation Level Status:

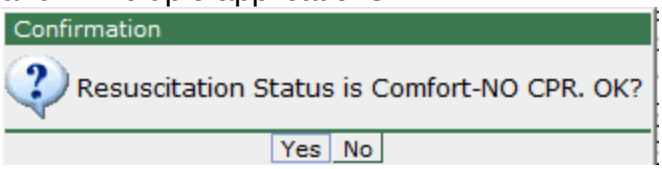
Enter into POM and select Resuscitation order.
The last Resuscitation order needs to be completed, before ordering the new Status

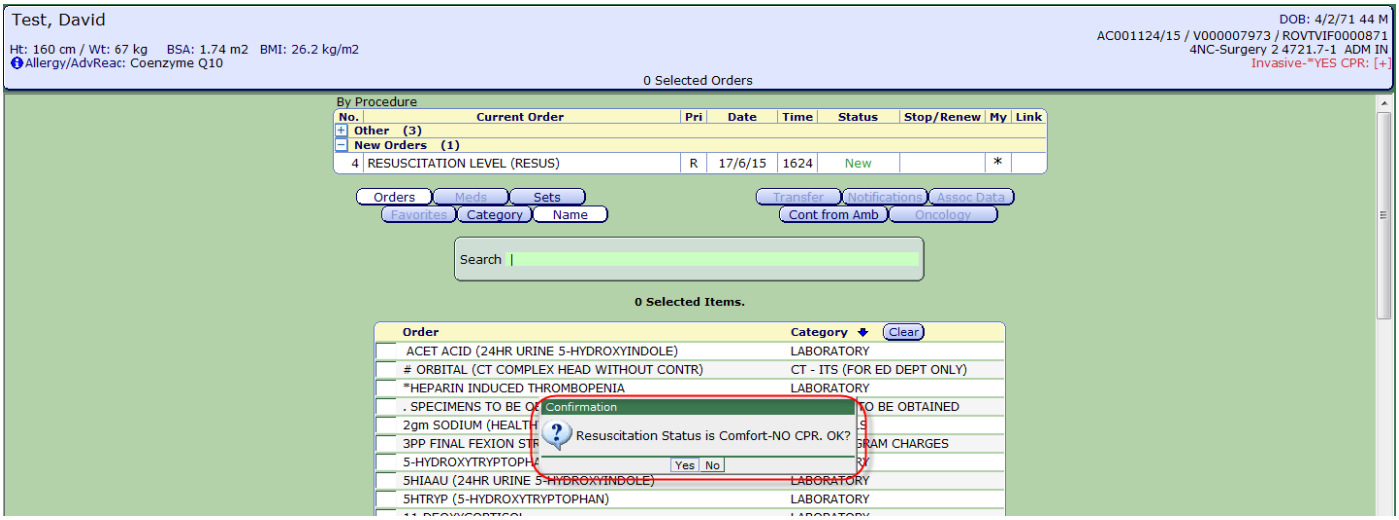


Once complete this Order is selected the resuscitation order automatically displays for the user to enter in the new Level.

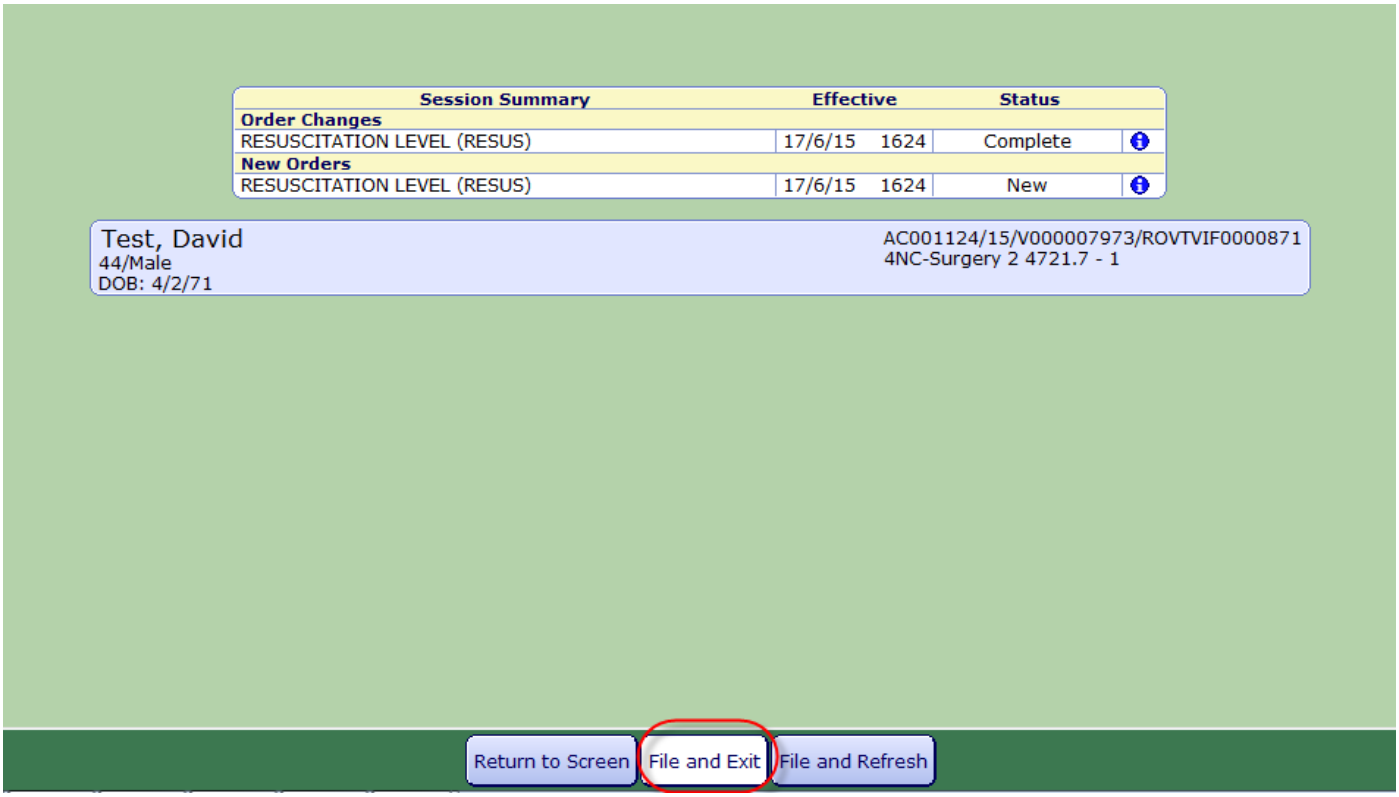


Confirmation pop up message when user files the order *(safety check).*
If yes is selected user continues to file order and Resuscitation Level displays on the header and in multiple applications

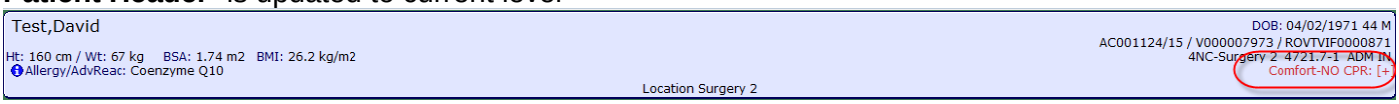




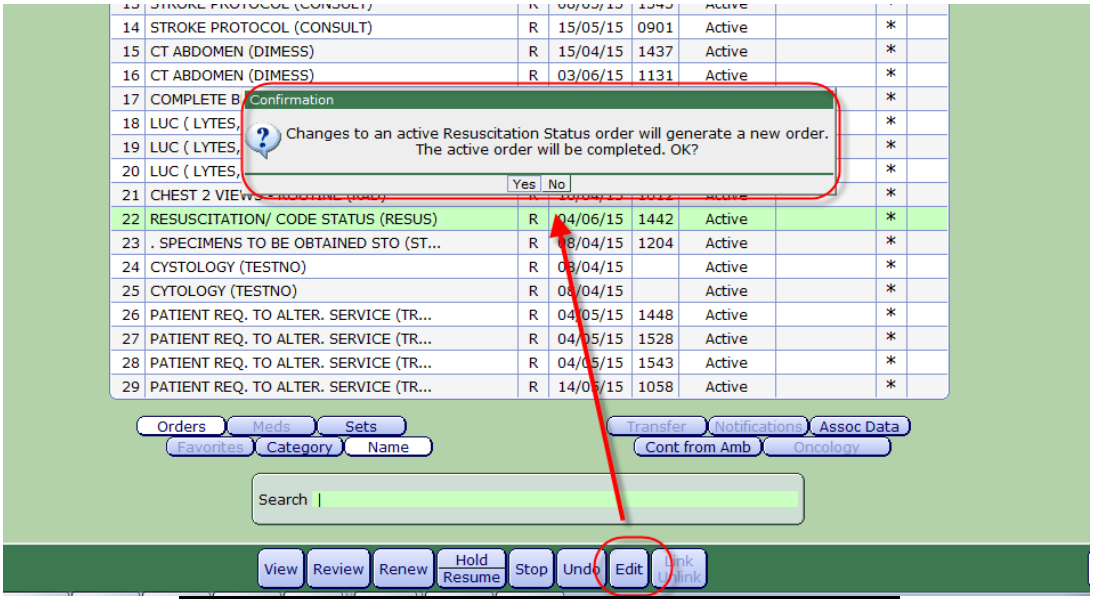
Confirmation screen and then FILE and Exit.



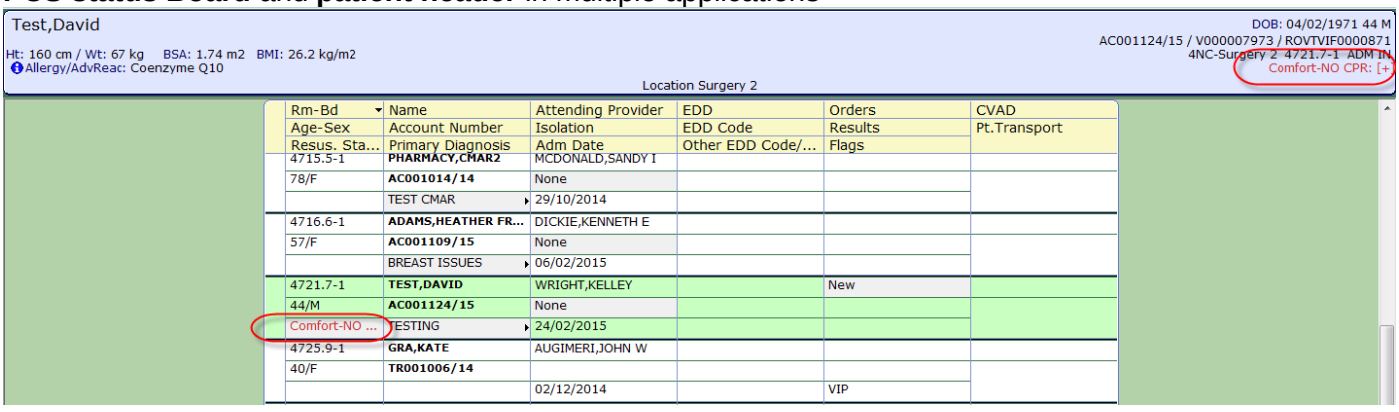
Patient Header- is updated to current level



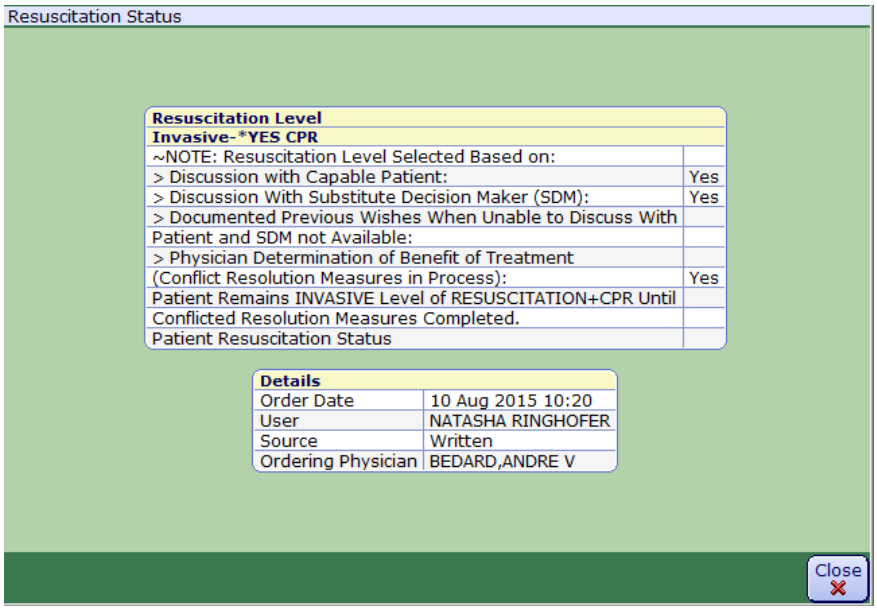
IF, Making an Edit This will process a new order and file appropriately.



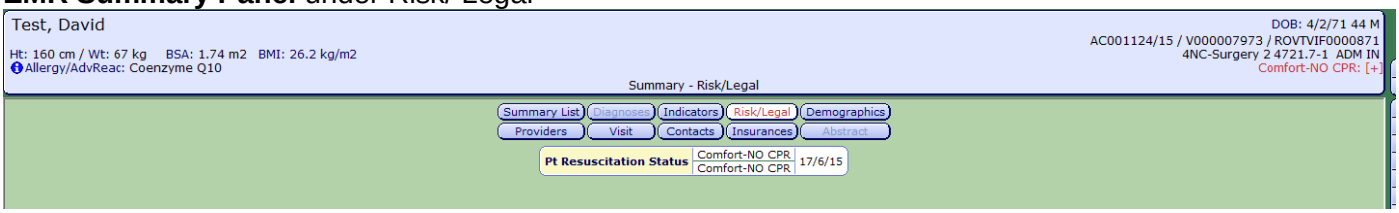
PCS status Board and **patient header** in multiple applications

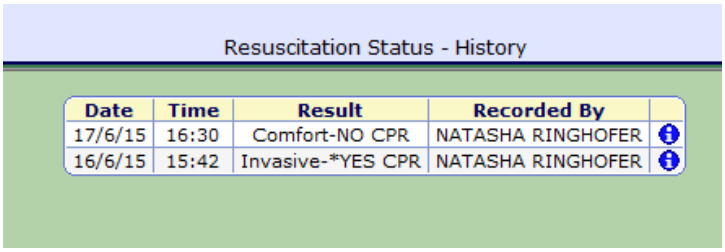


When the (+) is selected in the patient Header the details of the order display.



EMR Summary Panel under Risk/ Legal





Model for Consensus Building – Appendix D

Documentation must be completed at each step

Uncertainty, distress, disagreement between patient/SDM and MRP, or the patient/SDM and members of the health care team or among the members of the patient's hearth care team

↓

Second opinion from another physician

↓

Hospital Support:
Confer with palliative care program, social work, clinical ethics consultation or spiritual care

↓

Consult with Ethics Committee and Consent Capacity Board

↓

Document that you have explained the role of the CCB. Give family time to ask questions

Substitute Decision Maker Hierarchy – Appendix E

Substitute Decision Makers are ranked in a hierarchy. The order is:

1. A guardian appointed by the court if the court authorizes the guardian to make health care decisions
2. A person with a “power of attorney for personal care” authorizing him/her to make health care decisions
3. A representative appointed by the Consent and Capacity Board (any person may apply to the board to be appointed as the substitute decision maker)
4. A spouse or partner
5. A child or parent (custodial parent if the patient is a minor)
6. A parent who has access rights (if the patient is a minor)
7. A brother or sister
8. Any other relative
9. The Ontario Public Guardian and Trustee.

Making Substitute Health Care Decisions, The Role of the Public Guardian and Trustee. 2015