Decisions About Life Support Interventions, Including CPR: Addressing Communication and Disagreement

Sunnybrook Health Sciences Centre		**Policy No:**	PC-127
Title	**Decisions About Life Support Interventions, Including CPR: Addressing Communication and Disagreement**	**Original:** *(mm/dd/yyyy)*	04/14/2009
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Issued By:	Department of Critical Care Medicine		
Approved By:	Medical Advisory Committee		

The Sunnybrook Intranet document is considered the most current. Please ensure that you have reviewed all linked documents and other referenced materials within this page.

PURPOSE:

The policy is intended to:

- encourage timely and effective communication and collaborative decision-making among Patients, their families and the health care team,
- ensure that only those medical interventions that offer a realistic likelihood of medical benefit (in accordance with guidance provided by the Canadian Medical Association's Joint Statement on Resuscitative Interventions) are offered or provided, and
- provide a practical framework for addressing disagreement between Patients / Families and health care providers regarding the appropriate use of medical therapies such as Life Support Interventions, including CPR.

The focus of this policy is to provide a framework to guide decision-making in relation to Life Support Interventions for patients at high risk of dying. However, the principles outlined here for addressing disagreement are also applicable to decisions regarding other medical interventions for patients who are not critically ill.

ORGANIZATIONAL VALUES STATEMENT:

All end of life policies at Sunnybrook were developed in accordance with the following Organizational Values Statement:

Sunnybrook is committed to providing compassionate and quality end-of-life care that emphasizes respect for comfort and dignity of the Patient and the Patient's family.

Quality end-of-life care is an integral part of the continuum of care offered to our Patients and families. It is care provided at the stage when a Patient is dying despite efforts to treat or cure the Patient's life threatening illness or injury. At this stage of critical illness or post-injury, further life-sustaining therapies may not be available, wanted by the Patient or Patient's family, or considered medically advisable

Quality end-of-life care must be consistent with professionally recognized standards for care. This care requires clear and comprehensive communication regarding all available health care options. Timely, respectful communication demonstrates sensitivity to the wishes, feelings and information needs of the Patient and family. At Sunnybrook we are committed to a collaborative decision-making model. This model includes the contribution of Patients, families and interprofessional team members, with adherence to principles of informed consent as well as organizational and professional guidelines.

The interdisciplinary team takes into consideration and is sensitive to cultural and religious values when assisting Patients and their families in identifying and assessing appropriate resources and care options.

Quality end-of-life care is measured by best practice standards and values-based activities of the health care team and by the way Patients and families experience and perceive this care.

DEFINITIONS:

Patient:
Any individual receiving health care services at Sunnybrook.

Cardiopulmonary Resuscitation (CPR):

Interventions initiated in response to unresponsiveness accompanied by absent respiratory effort and/or pulselessness, such as mouth-to-mouth resuscitation, bag-valve-mask positive pressure ventilation, and endotracheal intubation, chest compressions, defibrillation, and advanced cardiac life support drugs.

Consent and Capacity Board:
An independent body created by the provincial government of Ontario under the Health Care Consent Act, which conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act and the Mandatory Blood Testing Act. Board members are psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council.

Do Not Resuscitate (DNR):
A physician order intended to direct staff not to initiate CPR. It may also be intended to direct staff not to initiate other Life Support Interventions.

Family:
Those closest to the patient in knowledge, care and affection. Family may include the biological family, the family of acquisition (by marriage / contract) and / or friends. The patient defines who will be involved in his / her care and at the bedside.

Life Support Interventions:
Physiologic intervention(s) intended to stabilize a Patient who would otherwise be expected to die. For the purpose of this policy, the term Life Support Interventions is intended to be inclusive, referring not only to advanced technologies such as mechanical ventilation, temporary cardiac pacing, inotrope/vasopressor therapy, intra-aortic balloon counterpulsation, and dialysis, but also cardiopulmonary resuscitation and other less complex interventions such as TPN, artificial feeding, intravenous hydration, and antimicrobials for life-threatening infections.

Standard of Care:
The care provided by a reasonable health care provider who possesses and exercises the skill, knowledge and judgement of the normal prudent practitioner of his or her special group.

Health Care Consent Act 1996:
Legislation establishing the right of people in Ontario to make informed decisions about health treatment. The Act covers all the elements of consent to health services and treatment provided in all settings by health practitioners specified in the Act.

Substitute Decision Maker (SDM):
Someone who (in accordance with the Health Care Consent Act) acts on behalf of the patient if the patient is not mentally capable of making health care decisions on their own behalf at the time health treatment is required (see also Sunnybrook Consent policy PC-0017).

Levels of Medical Benefit:
There can be many ways in which benefit is defined and understood by health care providers and recipients. This policy is informed by a definition of benefit provided by the Canadian Medical Association (CMA), as follows. The CMA document referenced CPR; its principles are applicable to other types of Life Support Interventions.

People who are likely to benefit from CPR: There is a good chance that CPR will restore cardiac and respiratory function and that the restored function will be maintained. The likelihood of the person returning to his or her pre-arrest condition is high.

People for whom benefit is uncertain: The person's condition or prognosis or both may not have been assessed before the loss of cardiac and respiratory function. It is unknown or uncertain whether CPR will restore functioning. The subsequent prognosis or the likelihood of adverse consequences is also unknown or uncertain.

People for whom benefit is unlikely: There is little chance that CPR will restore cardiac and respiratory function; even if the function is restored, it is unlikely to be maintained. The likelihood of the patient's returning to his or her pre-arrest condition is low.

(Canadian Medical Association Joint Statement on Resuscitative Interventions, 1995)

POLICY

The Decision to Offer Therapy

Patients should be offered Life Support Interventions, if this meets the standard of care as determined by the intervention's anticipated level of medical benefit.

The attending physician responsible for supervising Life Support Interventions is responsible for determining whether Life Support Interventions are anticipated to be medically beneficial for the Patient. In this determination of whether a treatment lies within the standard of medical care, physicians are expected to consider:

- risks and benefits of the therapy
- the values, wishes and interests of the Patient (as understood by the Family and / or SDM, where required)
- perspectives of consultants
- input from other members of the interprofessional team
- expected helpfulness of the potential treatment towards desirable outcomes
- relief and avoidance of distress, pain and other discomfort
- respect for human dignity
- existing laws and guidelines

In some situations the expected helpfulness of Life Support Interventions is not clear. The risk of death may be high, but there is at least some reasonable hope of recovery or improvement, and the Patient is expected to be able to experience benefit in the event of recovery from their illness. This may result in a decision to institute Life Support Interventions on a trial basis. Initiation of Life Support Interventions in such a circumstance does not necessarily imply that their ongoing provision is appropriate. The expected helpfulness of a treatment may change over time, and attending physicians supervising Life Support Interventions are expected to assess this parameter periodically during an admission.

In other situations, a physician may make an assessment that Life Support Interventions will not provide medical benefit, because they offer no reasonable hope of recovery or improvement, or because the person is permanently unable to experience any benefit. In such instances, Life Support Interventions should not be offered. This approach is compatible with recommendations from the Canadian Medical Association (see Levels of Medical Benefit).

Decisions concerning Life Support Interventions should be reviewed if there is a significant change in the Patient's condition.

Explaining A Decision To Not Offer Life Support Interventions

Communication with Patients / Families should be proactive and continuous throughout an admission, not simply reactive to the need for decisionmaking regarding Life Support Interventions.

Wherever possible, decisions to not initiate, continue or escalate Life Support Interventions should be discussed with the Patient, Family and other members of the interprofessional team in close proximity to documentation of the decision. Given the sensitivity of the subject matter, Patients and / or Family should be provided with the rationale

for this decision, while ensuring that the information being conveyed is understood by them with time provided to the Patient / Family for questions and discussion. If disagreement between the health care team and the Patient / Family about the decision to not offer Life Support Interventions exists, the process described under Conflict Management below should be followed.

The Decision To Accept or Decline Life Support Interventions Which Have Been Offered

Patients / SDMs have the right to accept or decline Life Support Interventions which have been offered by the medical service supervising Life Support Interventions. Patients should be encouraged to let their Family know about their decisions concerning Life Support Interventions.

Help will be made available to Patients and SDMs in relation to decisions regarding Life Support Interventions proposed by physicians responsible for the supervision of these services.

Life Support Interventions are not to be initiated if consent has been declined by a capable patient.

Other than these general principles, further discussion about consent to treatment is beyond the scope of this policy. Further information regarding capacity assessment, substitute decision making (including principles for how SDMs should make their decisions) and consent to treatment is available in Sunnybrook policy PC-0017 and the Ontario Health Care Consent Act.

Documentation Regarding Decisions About Life Support Interventions

Physicians must document their decisions regarding Life Support Interventions. These decisions should be discussed with the Patient / SDM / Family, and summary notes of discussions held with the Patient / SDM / Family about Life Support Interventions should be documented in the progress notes.

Where therapy is offered, consent should be discussed and documented. If Life Support Interventions (in general, or specific components) are not to be provided, the attending physician (or their delegate) must provide a written order on the Patient's order sheet to this effect. Orders may be specific (e.g. "No Cardioversion / Defibrillation", "No Chest Compressions", "No Mechanical Ventilation" or "No Pressors", or more general (e.g., "No CPR" or "Do Not

Resuscitate" or "Do Not Attempt Resuscitation").

NOTE: If orders to not perform any such interventions have been received by a nurse, the nurse is to place a green No CPR sheet ***"No Cardiopulmonary Resuscitation (NO CPR) Alert for Hospital File"*** in the front of the patient chart, to flag this order or order set. ***Order through Print Shop - Form # 61080.***

Decisions concerning Life Support Interventions should be reviewed if there is a significant change in the Patient's condition. There is no time limitation to orders restricting access to Life Support Interventions; a specific written order rescinding the previous order is required. When Patients are transferred from one facility to another or from one area in Sunnybrook to another, the Patient's candidacy for Life Support Interventions should be reviewed and clearly identified.

Implementation of Orders About Life Support Interventions

Patients will have access to CPR and other Life Support Interventions as indicated unless there are physician orders to the contrary on the Patient's chart, with the following exception: a Patient whose death is expected, or the SDM of such a Patient, may decline CPR in a discussion with a nurse. A nurse who receives such an instruction should document the Patient's decision, discuss end of life care with the Patient or SDM, and notify the physician of the Patient's decision. If such a Patient experiences cardiorespiratory arrest after declining CPR, health care providers are obliged to NOT initiate CPR.

Regardless of whether a ‘Code Blue' has been called, patients with a "No CPR" or "DNR" or "DNAR" order are not to receive any interventions in response to unresponsiveness accompanied by absent respiratory effort and/or pulselessness. Patients with "No Defibrillation", "No Chest Compressions", "No Intubation", "No Mechanical Ventilation" or "No Pressors" orders are also not to receive any interventions in response to unresponsiveness accompanied by absent respiratory effort and/or pulselessness.

A No CPR, DNR or DNAR order is NOT applicable to clinical presentations other than unresponsiveness accompanied by absent respiratory effort and/or pulselessness. An order to not provide CPR or other forms of Life Support Interventions does not automatically imply withholding or withdrawing any other treatment. Patients whose access to Life Support Interventions has been limited will receive access to all other appropriate treatment not specifically excluded.

Patients do not have to admit or accept that they are dying to receive

quality end of life care. Patients should be offered palliating interventions as appropriate for discomfort or distress. regardless of their degree of access to Life Support Interventions.

Surgery And Other Invasive Procedures for Patients With Orders Restricting Access to Life Support Interventions

Patients with No CPR orders or other orders restricting access to Life Support Interventions may still be candidates for surgery or other invasive procedures. It should not be assumed such an order is rescinded during the perioperative period. Perioperative implications of orders restricting access to Life Support Interventions should be fully discussed with the Patient / Family / SDM prior to surgery or other invasive procedures, and the results of these discussions documented with appropriate accompanying orders.

Addressing Conflicts Regarding Decisions To Not Offer Therapy

In the face of catastrophic illness or injury, even careful, thoughtful and sensitive decisions about life support can be emotionally charged. For example, there may be a request for Life Support Interventions that the medical service responsible for such interventions is not planning to offer. This situation can cause distress for all concerned.

Upon becoming aware of conflict regarding a decision to not initiate, continue or escalate Life Support Interventions, the attending physician responsible for the supervision of such Life Support Interventions should consider and document whether revision of the existing orders is necessary.

The process described below is intended to guide health care providers through difficult discussions relating to access to Life Support Interventions in the presence of conflict. Although the steps are presented in the order they would most likely occur, several steps may be undertaken simultaneously. It is recognized that the Patient's condition may not permit completion of this process.

The optimal outcome of this process is the resolution of conflict between the Patient / Family and the health care team via consensus. It is important that the health care team maintain dialogue with the Patient / Family as feasible, despite the presence of conflict. Best practices that model for respectful and effective communication should be sustained throughout the patient's admission.

COMMUNICATION PROCESS

Gathering Information

In collaboration with other members of the health care team, the attending physician responsible for supervising the Life Support Interventions at issue should:

- explore the details of what the Patient wanted, including their goals of care and views about Life Support Interventions
- share their perception of the Patient's prognosis and anticipated outcomes with the Patient / Family

Support

Members of the interprofessional team should assist the Patient / Family in identifying what hospital resources might be helpful to them, such as the Palliative Care team, social worker, chaplain, clinical ethics consultation and / or the Patient Relations Representative. Such resources can be of assistance not only to Patients / Family, but can provide support as well to the interprofessional health care team when a situation of conflict over care arises. Consideration should be given to helping the Patient / Family and interprofessional team assess needs early so that there can be timely involvement of consultation services, appropriate levels of support and relevant information when conflicts over care decisions first arise or are likely to arise.

Interprofessional Team Consensus

The health care team should attempt to reach consensus regarding the range of appropriate treatments to be offered, and clarify how each team member will contribute to meeting the goals of care. Seeking consultative input from other services (in particular the Clinical Ethics service) may be helpful if consensus cannot be reached. The health care team should consider the patient's wishes, values and beliefs, the patient's health status, professional guidelines, hospital policy, and acknowledged standards for care.

Negotiation

In instances where various options are deemed to be reasonable, the most responsible physician should discuss these options to attempt to determine whether a strategy that is acceptable to both the Patient / Family and the health care providers actively involved in the care of the Patient can be devised. This discussion should be attended by other members of the interprofessional team. The Patient Relations office may be of assistance in facilitating such discussions.

Second Opinion

If an approach which is acceptable to both the Patient / Family and the health care providers actively involved in the care of the Patient cannot be negotiated because of disagreement about the appropriateness of interventions, a second opinion from a physician with expertise relevant to the patient's condition and proposed therapy should be arranged by the attending physician responsible for supervising the Life Support Interventions at issue. The consulting physician should be asked to comment on whether the referring physician's decision to not offer Life Support Interventions is compatible with the consulting physician's perception as to the standard of care in this circumstance.

Legal Advice

When faced with unresolved conflict about Life Support Interventions including CPR, the most responsible physician may consult with a hospital lawyer regarding legal implications or options to be considered (such as an application to the Consent and Capacity Board). Hospital counsel may be accessed through the office of Quality and Patient Safety. After hours, the Shift Manager / Administrator on Call may be contacted via Locating.

Patient Transfer

If an approach acceptable to both the Patient / Family and the health care providers actively involved in the care of the Patient cannot be negotiated because of disagreement about the appropriateness of Life Support Interventions, the Patient / Family should be given the option of identifying another provider willing to assume care of the Patient. If possible, transfer to such a provider should be facilitated by the health care team.

Clarification and Notice

Patients and / or their Family should be offered regular and thorough information regarding the Patient's progress and prognosis. If the health care team intends to withdraw ongoing Life Support Interventions because the Patient almost certainly will not benefit or is expected to remain incapable of perceiving benefit, the Patient or Family must be informed of this intention in a timely way.

If a decision is reached to not initiate, escalate or continue Life Support Interventions, the most responsible physician should:

- offer a clear rationale as to why this decision has been reached

- offer palliative care measures as applicable
- assist the Patient / Family in identifying their needs
- document pertinent details of this communication in the Patient's health record

APPENDICES AND REFERENCES:

APPENDIX

No Cardiopulmonary Resuscitation ('NO CPR') Alert For Hospital File
Order from Print Shop using PR 61080 (2009/06/11)

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