STANDARD

New Zealand law requires that a patient be resuscitated where the procedure would be beneficial to him or her. Section 151 of the Crimes Act 1961 places a legal duty on health professionals to provide the necessities of life to patients. Further, necessary / reasonable treatment may not be withheld or withdrawn from a competent patient against their will.

OBJECTIVE

This protocol defines standards regarding cardiopulmonary resuscitation (CPR) and the decision making process on whether to provide CPR or not to particular patients.

- Section A sets out the standards for CPR.
- Section B sets out the standards required if either the patient or medical practitioner(s) do not consider CPR to be in the patient's best interest.

STANDARDS TO BE MET

SECTION A: patients / casualties FOR resuscitation

1. **In the absence of any other documentation completed in advance, the clinical staff should act in what appears clinically appropriate for the patient.**

2. All staff must know how to initiate the emergency call to the appropriate response team(s) listed below: *Dial 777* and state your name, the type of emergency and the location:
   2.1 Adult Cardiac Arrest / Medical Emergency Call
   2.2 Adult Trauma Call
   2.3 Paediatric Cardiac Arrest / Medical Emergency
   2.4 Paediatric Trauma
   2.5 Obstetric Emergency

3. Some areas have *Medical Emergency 777 PULL or PUSH buttons* which activates the MET group immediately. This button may be pulled (or pushed) in place of the 777 phone call. If the button is linked to the 777 Medical emergency pagers it will clearly state '777' on, or near the button.

4. The Emergency Department (ED) also has a protocol regarding multiple medical emergency presentations, or multiple trauma presentations (refer ED.A11.1). These are defined as CODES.
   a) Code 1 for one (1) seriously ill person
   b) Code 2 for two (2) seriously ill people
   c) Code 3 for three (3)
   d) Code 4 for 4-5 people
   e) Code 5 for 6-8 people
   f) Code 6 for 9+ casualties

5. Each code has an escalating number of staff to attend, as held by Telephony.

6. Each staff member involved in an emergency event is required to carry out their role as per protocol according to their training level.

7. Each staff member who carries a cardiac arrest pager is responsible for:
   7.1 Ensuring their resuscitation skill certificate is current to the appropriate level for their post
   7.2 Knowing how to access each of the clinical services they are covering.

7.3 Ensuring the pager is retained on their person at all times during their shift, turned on with a good battery and not changed to vibrating / silent mode.

7.4 Ensuring that pager batteries are checked daily and changed fortnightly or when low cell sound is heard.

7.5 Ensure that red emergency pagers / on call cellphones are handed over at shift changes, in person.

8. The most senior medical practitioner who has responded to the cardiac arrest call is responsible for:

8.1 Delegating a team leader.

8.2 Documentation in the patient's health record.

8.3 Notifying the responsible senior medical officer (SMO).

8.4 Completing a new Clinical Staff Event in the 777 Clinical Emergency Calls Register and Resuscitation Flowchart (located on emergency trolley). This may be delegated to the Nurse Shift Leader of the area.

   a) Tauranga - send to the Resuscitation Co-ordinator

   b) Whakatane - send to the Resuscitation Co-ordinator

9. All locum medical practitioners who will carry the 'Red-Pager' are responsible ~~of~~ for ensuring that their advanced resuscitation skills (NZRC level 7 or equivalent) are up to date – within the last 3 years, and that they are aware of the New Zealand Resuscitation Council standards. They must familiarise themselves with the hospital layout, equipment (especially defibrillators), and emergency suction on arrival.

10. During resuscitation the healthcare team will make a collaborative decision regarding family / whanau presence. Staff are required to utilise professional judgement to give the necessary and appropriate support to significant other(s) and healthcare team members.

11. There must be at least one (1) resuscitation trolley in each clinical area, a resuscitation pack in each service without a trolley, and staff must be aware of its location.

12. Each resuscitation trolley or pack must carry the contents approved in writing by the Resuscitation Committee.

13. Resuscitation trolleys and packs must be maintained according to protocol.

14. Every ~~health~~ practitioner required to be involved in resuscitation or form part of the resuscitation team must have undertaken appropriate CPR training according to BOPDHB policy 6.3.7 protocol 5 Life Support Training.

15. Any staff concerns arising from a resuscitation event will be addressed by appropriate incident debriefing and / or provision of confidential and professional counselling.

16. **Reporting of 777 calls**

  a) **Ward Nursing Co-ordinators go to:**

    i. OnePlace / Tools / Reporting / 777 & Cardiac Arrest Calls
Reporter is to:

     • choose from the selection boxes - select Tauranga Hospital or Whakatane Hospital Location "Nurses / Doctors report"

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Cardiac arrest & 777 Clinical Emergency Calls Register

Fill in below as necessary

All details are recorded on the above screen, then saved.

b) Telephony also record system details to ensure 777 calls are audited and reviewed as necessary.

c) **Resuscitation Co-ordinators**

   i. A summary of 777 responses is provided to the Resuscitation Committee at their scheduled meetings.

   ii. Clinical emergency 777 calls will be reviewed weekly by the Resuscitation Co-ordinator and audited.

SECTION B: Resuscitation Status Ceiling Of Intervention (COI). **'DO NOT ATTEMPT RESUSCITATION (DNAR) / ALLOW NATURAL DEATH (AND)' is part of the COI (7447) form. There is no separate NFR form.**

1. **In the absence of any other documentation completed in advance, medical practitioners should act in what appears clinically appropriate for the patient.**

2. End-of-life and resuscitation decisions are to be made early in the patient's care, such as following discussion in the ED / Admission Planning Unit (APU) and may be patient or health practitioner initiated.

3. The COI form (7447) is to be completed by a medical practitioner (PGY3 or above) as soon as possible on admission for all patients.

4. Medical practitioners should follow a robust decision-making process in making the decision regarding a DNAR / AND, as per protocol 1.

5. A competent patient may at any time make a free and informed request not to be resuscitated, in accordance with BOPDHB policy 1.1.1 Informed Consent.

6. All decisions / advance directives should be appropriately documented by use of the designated forms and documented in the patient's health record.

7. <u>Characteristics Of Patients For Whom 'DNAR / AND' Decision May Be Appropriate.</u>
   a) Any patient who after end-of life discussions wishes 'natural death' in the event of a cardiac arrest .
   b) Patients with a very poor prognosis for whom resuscitation would be clinically futile (see Definitions) should be considered 'DNAR / AND'.
   c) Consideration of the poor prognosis needs to include:
      i. quality and length of life which needs to be assessed as accurately as possible,
      ii. likely disease / illness progression,
      iii. assessment of the attitudes of all involved in the decision-making, to ensure that paternalism is not over-riding the patient's right to have autonomy, dignity and respect.

8. <u>Making The 'DNAR / AND' Decision</u>
   a) Protocol 1 provides a Synopsis of the Resuscitation Decision-Making Process.
   b) Protocol 2 provides guidelines for discussing <u>DNAR / AND</u> authorisation with patients and others.
   c) It is crucial to involve a **competent patient** in the decision making process. Informed consent, if required, should be obtained in accordance with the requirements of BOPDHB policy 1.1.1 Informed Consent.
   d) Where the patient is **not competent**, key persons e.g. the family / whanau or Enduring Power of Attorney may be consulted to assist in determining the patient's wishes, and their names and relationship to the patient identified and documented in the patient's health record. The requirements of policy 1.1.1 Informed Consent provide further guidance in this circumstance. It is important that staff understand the difference between normal Power of Attorney, and Enduring Power of Attorney - with Personal Care and Welfare power.
   e) No person (unless authorised under an Enduring Power of Attorney) is legally entitled to consent or refuse consent to medical treatment on the behalf of an adult who lacks decision-making capacity. They should be consulted and their views taken into account, but they cannot insist on treatment or non-treatment. However, if such a party continues to disagree with a medical practitioner's recommendation to make a 'DNAR / AND', the medical practitioner should seek legal advice from the BOPDHB

Legal Advisor. If there is any doubt or a decision has not yet been made, routine CPR should be performed without delay

f) The patient may have made an **advance directive**. The issues surrounding an advance directive are similar to those relating to any patient's consent to a procedure / treatment. These are whether the patient:
   i. was competent to make the particular decision, when the decision was made; and
   ii. made the decision free from undue influence; and
   iii. was sufficiently informed to make the decision; and
   iv. intended his / her directive or choice to apply to the present circumstances.
g) Advance directives are not necessarily binding.
h) Any staff discussion that intends to revoke an DNAR / AND authorisation should involve:
   i. The patient's medical practitioner
   ii. A suitably experienced nurse e.g. ward co-ordinator
   iii. Other staff as appropriate.

9. Patient or Health Practitioner Initiated DNAR / AND
   a) The New Zealand Bill of Rights 1990 Section 11 states: Everyone has the right to refuse any medical treatment. There is no legal requirement that life saving treatment must be given if a competent (refer to Glossary of Terms / Definitions) patient does not want it.
   b) All patients requesting DNAR / AND status should be given a copy of the BOPDHB Resuscitation Patient Information Sheet and an appropriate member of staff should be available to discuss the contents with them (see Protocols 1 and 2).
   c) If a competent patient makes a free and informed request not to be resuscitated the request should be documented on the COI form (7447) and in the patient's health record (this is the equivalent of Informed Consent).
   d) Signature of the COI form by the medical practitioner indicates that this information has been given to and has been understood by the patient.
   e) Such a request should be current (see BOPDHB Glossary of Terms / Definitions as determined by the clinical team. The consultant has ultimate responsibility for this.
   f) If there is incongruity between the patient's request not to be resuscitated, and the patient's likely clinical outcome, then the patient must be assessed and advised by the registrar on duty or the responsible consultant. Psychiatric assessment may be requested if needed, and legal advice sought from BOPDHB Legal Advisor.

10. Medically Initiated DNAR / AND
    a) When a patient approaches the end of any terminal process, or their perception of end of natural life, and death is anticipated, the staff responsible for the patient's care should review the appropriateness of the treatment plan, including decisions about resuscitation.
    b) No health professional is required to provide clinical treatment that is not clinically indicated. CPR does not differ from other clinical treatments / procedures in that **it should be used only where it can be of benefit to the patient.**
    c) Any patient receiving palliative care, rather that active treatment, should have resuscitation attempt discussed with them. Hospice patients generally sign a DNAR / AND form at their admitting centre (e.g. Waipuna Hospice). However, Oncology / Cancer Centre patients are for resuscitation unless the part of the COI form has been signed.
    d) There are circumstances in which the decision COI form should be made in consultation with the patient's key person(s). These circumstances include where:

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  i. it is acknowledged that a terminally ill patient has indicated that they do not wish to be fully informed about their condition or to be involved in decision-making. The wishes of such patients should be respected and clearly documented in the patient's health record. It is recommended that this be countersigned by another clinical staff member.

  ii. the patient cannot make the decision and seeks to have the decision made for them.

  iii. the patient is incompetent e.g. because of a decreased level of consciousness, some forms of aphasia, patient is a baby or child, etc.

e) In all such cases, the medical practitioner must:

  i. clearly identify the status of key persons and as far as possible verify that they are in fact the patient's approved spokesperson(s).

  ii. for Māori, clearly identify the whānau spokesperson for the patient. Regional Maori Health Service (Te Pou Kokiri Whakatane, Kaupapa Social Workers Tauranga) can be used to assist in communication with whānau.

  iii. discuss the patient's situation in detail with the patient's key person(s) if they are available (reasonable attempts must be made to locate them). A copy of the BOPDHB Resuscitation Patient Information Sheet can be provided to the key person(s) if it is felt it can help decision-making.

  iv. ensure the patient's cultural requirements are met as far as possible

f) Where there is conflict between key persons, they should be encouraged to meet and agree. If no agreement is reached, the Consultant / delegated Registrar will decide in consultation with the clinical team. The consultant should access legal advice if needed from BOPDHB Legal Advisor.

g) Where the patient is an **incompetent child**, and where the parent or guardian requests DNAR / AND status for the patient, a COI form (7447) may be signed.

h) Where the patient is a **competent child**, and where the parent or guardian requests DNAR / AND status for the patient, the Consultant / delegated Registrar should seek advice from the BOPDHB Legal Advisor.

i) Where a patient is an **incompetent adult** without a welfare guardian appointed, or for any patient where resuscitation is not clinically indicated, a COI form (7447) must be completed by the medical practitioner PGY3 or above. This ensures clarity of communication with other members of the clinical team, and also records information provided to key persons. This is necessary to ensure all staff are clear whether resuscitation is to be attempted or not.

j) The topics listed on the COI form (7447) should be discussed with the patient and / or key persons, as appropriate. Further guidance on topics that should be discussed with key persons may be found in Protocol 2 Guidelines For Discussing DNAR / AND Authorisations.

k) The medical practitioner may feel that discussion with the patient / key person(s) regarding DNAR / AND is inappropriate given an individual patient's circumstances. However, it is essential that the patient and / or key person(s) must be aware that death due to the illness / disease is certain and cannot be prevented, and that any resuscitation effort would not have a good outcome. Allowing natural death gives family time to prepare for the conclusion of life. This allows for key person(s) to ask questions and clarify the situation.

l) Signature on the COI form (7447) (Protocol 4) by medical practitioners indicates the information has been given or attempted to be given and the staff believe it was understood by the patient or family / whanau. In authorising a medically initiated DNAR / AND authorisation, the medical practitioner accepts responsibility for the non-performance of resuscitation attempt.

m) Where there is conflict between the medical practitioner and the patient / guardian regarding a DNAR / AND decision, advice from the BOPDHB Legal Advisor should be sought.

11. Documentation Of The Patient's COI Status
    a) In all cases the decision not to attempt resuscitation must be fully documented in the patient's health record on the COI form (7447).
    b) The patient's DNAR / AND status may only be documented by a medical practitioner PGY3 or above.
    c) The reasons underlying the medically initiated COI should be clearly documented on the COI form itself and additional notes can also be made in the patient's health record.
    d) If a patient arrives at the hospital from a REST HOME with a DNAR / AND form signed by themselves, family / whanau member or Power of Attorney, on an appropriate but non-DHB form, this should be adhered to. No further discussion is necessary, except if clarification is required. A COI form should be completed on arrival to hospital.
    e) The appropriate rest home should be contacted and a faxed copy obtained if no DNAR / AND form is brought with the patient.

12. Revoking A Not For Resuscitation Authorisation
    a) If the patient wishes to revoke a *Patient Initiated COI Authorisation*, or the medical practitioner decides that a *Medically Initiated COI Authorisation* is no longer appropriate, then the COI form must be ruled through diagonally in ink and endorsed VOID, and this action highlighted in the patient's health record, and nursing staff informed. The endorsement must be dated and signed by the:
        i. Consultant or medical practitioner PGY3 or above, with the full name and designation of the medical practitioner stated; and
        ii. patient - in the case of the Patient Initiated DNAR / AND Authorisation.
        iii. A new COI form is needed for the rest of the current admission.

13. Reviewing a COI Authorisation
    a) The medical practitioner will ensure regular monitoring of changes in the patient's health status that are relevant to determining the appropriateness of continuing the COI status of the patient and if necessary call a meeting of the team and key persons.
    b) The COI decision must be re-evaluated and re-documented:
        i. on each admission; or
        ii. whenever the patient's health status alters.

14. Treatment Of Patients Who Are DNAR / AND
    a) Patients who are DNAR / AND, must still receive such treatment as deemed appropriate by the consultant and in consultation with members of the clinical team.
    b) A COI order should not affect other medical or nursing care.
    c) The COI form also outlines the ceiling of intervention given to the patient. A 777 call should ALWAYS be put out for the peri-arrest patient who has not cardiac arrested, and the attending medical practitioner (team leader) advised of the COI form instructions for further care.

15. Success Indicators
    a) A Post-Resuscitation Audit Form is completed for each resuscitation event and sent to the Resuscitation Committee. This form does not need to be completed if CPR / resuscitation is not attempted.
    b) For All patients:
        i. COI form (7447) is completed for all inpatients.

ii. On each admission a new COI form is completed and dated, then placed in the front cover of the patient's health record.
iii. On discharge the COI form is to be crossed through and marked VOID and dated.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.3.7 Cardiopulmonary Resuscitation (CPR)
- Bay of Plenty District Health Board policy 6.3.7 protocol 1 - CPR - Decision Making Process
- Bay of Plenty District Health Board policy 6.3.7 protocol 2 – CPR - Discussing 'NFR' Authorisation With Patients And Key Persons
- Bay of Plenty District Health Board policy 6.3.7 protocol 3 – CPR - Maintenance of Resuscitation Equipment
- Bay of Plenty District Health Board policy 6.3.7 protocol 4 – CPR – Life Support Training
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.C2.1 Cardiopulmonary Resuscitation (CPR)
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.C2.2 CPR - Use of Automated External Defibrillation (AED)
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 6.1.4 Advanced Directives
- Bay of Plenty District Health Board policy 6.1.5 protocol 1 Alerts – Medical – Allergic Responses, Adverse Reaction and High Risk Issues
- Bay of Plenty District Health Board policy 7.103.1 protocol 17 Certification - Life Support
- Bay of Plenty District Health Board Hospital Support Services protocol HSS.T1.1 777 Response Procedure (Durapage)
- Bay of Plenty District Health Board What is Resuscitation, and what are my options. Patient Information Brochure – *viewable only. Order from Design & Print Centre*
- Bay of Plenty District Health Board Resuscitation Status Ceiling of Intervention (COI) (7447) – *viewable only. Order from Design & Print Centre*
- Bay of Plenty District Health Board 777 phone list - Emergency Response list per groups (TGA & WHK)
- Bay of Plenty District Health Board Form FM.A11.1 Alert - Medical
- Bay of Plenty District Health Board 777 Clinical Emergency Calls Register