FNIHB- OR Nursing Policy and Procedure

Section:	**Administration**	Policy Number:	**I - 12**
Subject:	**Do Not Resuscitate Order**	Issued: Revised:	**2015-03-31**
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 A Do Not Resuscitate (DNR) order must be ordered by a physician and clearly documented in the client's health record.

1.2 Where a previously arranged instruction from the client exists, either as an advanced directive, living will, or written DNR order from another institution, it should be respected, providing the physician is satisfied that:

i. The document is valid;
ii. The elapsed time since the document was drafted is (in the physician's judgment) reasonable,
iii. The client's condition has not undergone enough change to warrant a new decision,
iv. The client's wishes have not changed.

1.3 A capable client or substitute decision maker may request that a voluntary DNR order be rescinded at any time. Provided that CPR is medically supportable, such a request must be followed by a written order and an accompanying progress note explaining the change.

2. PRINCIPLES:

2.1 The goal of end-of-life care is to improve the quality of living and dying, and minimize unnecessary suffering. It encompasses the physician, spiritual, social, psychosocial, cultural and emotional dimensions of client care (CNO, 2009).

2.2 FNIHB framework supports the principles of client self-determination and thereby encourages clients to be active participants in the health care decision making processes. Nurses should be familiar with legislation and their organization's policies about the use of advance directives.

2.3 All adults are presumed to be capable of making health care decisions until there is clear evidence that the client is incapable of making a clear decision. Capability and incapability is assessed on the client's understanding (1) Of the information being given to him/her and (2) That the

information applies to his/her own situation.

2.4 The *Health Care Consent Act (1996) and Substitute Decisions Act (1992)* enable a capable person to create an advance directive. Through an advance directive, the person can indicate the kinds of treatment he / she would like to be accepted or rejected in the event that the person becomes incapable. If the person becomes incapable, these directives would be interpreted by the person's substitute decision-maker.

3. DEFINITIONS:

Advanced Directive: the means used to document and communicate to a substitute decision-maker a client's preferences regarding treatment in the event that the client becomes incapable of expressing those wishes.

Capable: A client is capable when he or she can understand the information that is relevant to making a decision about treatment, and appreciate the reasonably predictable consequences of a decision or lack of decision.

Do Not Resuscitate (DNR): means the practitioner will not initiate basic or advanced cardiopulmonary resuscitation (e.g. Chest compression, defibrillation, artificial ventilation, intubation, transcutaneous pacing, insertion of an oropharyngeal or nasopharyngeal airway, and advanced resuscitation drugs).

End of Life Care: Refers to the care that is provided to a client at the end of his/her life.

Nurse: Refers to Registered Nurses, Nurse Practitioners, and Registered Practical Nurses.

Resuscitation: An invasive and immediate life-saving treatment that is administered to a client who has a sudden unexpected cardiac or respiratory arrest. It may include basic cardiac life support involving the application of artificial ventilation (such as mouth-to-mouth resuscitation and bagging) and chest compression. It may also include advanced cardiac life support, such as intubation and the application of a defibrillator.

Substitute decision-maker: The person who is authorized to give or refuse consent on behalf of an incapable client. The substitute decision-maker may be a relative or a specially appointed person, such as someone with power of attorney for personal care.

4. PROCEDURE:

4.1 The attending physician shall discuss end of life care with the client (if capable) or if the client is not capable, with the substitute decision maker (SDM) or power of attorney (POA).
Note: If a SDM or POA is not readily known, the physician or delegate must make a reasonable attempt to identify a person capable of making decisions on behalf of the client.

4.2 The *Health Care Consent Act*, S. 21, outlines the Hierarchy for identifying SDMs for a client:

1. Guardian of the Person with authority for Health Decisions
2. Attorney for personal care with authority for Health Decisions
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child or Parent or CAS (person with right of custody)
6. Parent with right of access
7. Brother or sister
8. Any other relative
9. Office of the Public Guardian and Trustee

4.3 The end of life discussions with the client / SDM / POA leading up to the DNR order shall be recorded on the client's health record. This should include:

4.3.1 Client's prognosis, including likelihood of reversing the illness, and agreement on prognosis among consulting physicians;

4.3.2 Discussions of treatment plan and options with the client or substitute decision maker, as well as others on the health care team;

4.3.3 Views of the client or substitute decision maker, concerned with client's comfort

4.4 In the event a physician is not present in the community to document the DNR order in the client's record, a telephone order may be given. The telephone order must be verified by two staff members, one of whom shall be a Registered Nurse.

4.5 When a DNR order is written, the nurse shall document the DNR status on:

4.5.1 The Patient Profile Sheet at the beginning of the client record, along with the contact information for any substitute decision maker or POA. This entry should also include the date and time the DNR order was obtained.

4.5.2 An alert sticker adhered to the inside of the front cover of the health record. Do not place the alert sticker to the outside of the health record, to safeguard confidential information.

4.6 Once a DNR order is in place, the care team providers will not administer chest compressions, insert an artificial airway, administer resuscitative drugs, defibrillate or cardiovert, provide respiratory assistance (other than suctioning the airway and administering oxygen), initiate resuscitative IV, or initiate cardiac monitoring.

4.7 The DNR order does not prohibit nurses and other health care providers from suctioning an airway, administering oxygen, positioning the client for comfort, splinting or immobilizing, controlling bleeding, providing pain medications, providing emotional support, or contacting other appropriate health care providers as required.

4.8 If the client is found to be in cardiac or respiratory arrest and end of life care decisions are not known, CPR is to be started immediately. Once the client's code status is confirmed to be DNR, then the team will immediately stop CPR efforts and maintain comfort measures (stated in statement 4.7) as clinically indicated.

4.9 Nursing Responsibilities with End of Life Care Decisions:

4.9.1 The nurse has a responsibility to advocate for the client by contributing to ongoing communication about end of life care wishes, implementing the client's wishes by documenting a plan of care, and communicating any changes in wishes to the Circle of Care Members.

4.9.2 The nurse may act on behalf of the client to help clarify the plans for treatment when:

i. The client's condition has changed and it may be necessary to modify a previous decision;
ii. The nurse is concerned the client may not have been informed of all elements in the plan of treatment, including the provision or withholding of treatment
iii. The nurse disagrees with the physician's plan of treatment; and
iv. The client's family disagrees with the client's expressed treatment wishes.

4.9.3 Documenting a written plan of care that supports the client's wishes for end of life treatment decisions. In addition to the specific treatment decisions (e.g. DNR status), this plan of care should also include the following:

i. SDM / POA contact information
ii. Identifying whom to notify when the client dies
iii. Identifying the most appropriate health care provider to notify the family (e.g. NIC, SW, or CHN, etc.)
iv. Identifying the client's and family's cultural and religious beliefs and values about death and post mortem care of the body
v. Identifying whether the family wants to see the body after death has occurred;

5. RELATED POLICIES:

FNIHB-OR Policy: Documentation Standards
FNIHB-OR Policy: Post Mortem Care
FNIHB=OR Policy: Pronouncement and Certification of Death

5. REFERENCES:

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Approved by:	**Effective Date:**
	March 31, 2015
Director of Nursing, Ontario Region FNIHB **Date:**	
Regional Executive, Ontario Region, FNIHB **Date:**	