

Policy Applies To:

All Mercy Hospital Nursing Staff and Credentialed Specialists.

Related Standards:

EQuIP standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process

Criterion 1.1.7 Systems exist to ensure that care of the dying is managed with dignity and comfort (refer to the 'Death of a patient' policy)

The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

RIGHT 7; Right to Make an Informed Choice and Give Informed Consent

7) Every consumer has the right to refuse services and to withdraw consent to services.

Rationale:

Established guiding principles for the management of end of life decisions need to be available to ensure that both the patients and Mercy hospitals rights and responsibilities are met.

It is acknowledged that death is a part of life, and for some patients, the natural endpoint of his/her current clinical condition may be death.

As Mercy Hospital is an elective surgical hospital the likelihood of a Do Not Resuscitate (DNR) request being made is much less likely than that of an acute admitting hospital.

Definitions:

Advance Directive

This is defined in the Code of Health and Disability Services Consumer's Rights as *'a written or oral directive – (a) by which a consumer makes a choice about a possible future health care procedure; and (b) that is intended to be effective only when he or she is not competent.*

Right 7(5) of the Code states that: *'every consumer may use an advance directive in accordance with the common law.'* (refer Consent Policy)

Competent

A person is competent when there are reasonable grounds for believing that the patient has the capacity to understand the information, appreciate the situation and manipulate the information.

“The doctor should consider whether at the time the patient had a capacity which was commensurate with the gravity of the decision which the patient purported to make. The more serious the decision, the greater the capacity required.” Lord Donaldson, M.R., cited pgs 174 and 175, “Medical Law in New Zealand”, Skegg Paterson Ed, 2006, Thomson Brookers. Refer to Mercy Hospital Consent policy).

Objectives:

- All patients have a right to be informed and to make choices about their care and treatment
- To ensure that there is a system in place to support end of life decision making processes
- Provide comfort, respect and dignity for the dying patient and their family.

Implementation:

Policy available on the website for Credentialed Specialists

By-laws for Credentialed Specialists on the website

Staff education on NFR referenced in Consent education, as needed.

Evaluation:

- All NFR Authorisations are documented on the appropriate form
- All NFR Authorisations are re-documented on each admission
- Patient/family feedback sought.

Associated Documents

External

(This is not exclusive)

- Crimes Act 1961
- Code of Health and Disability Service Consumers' Rights 1996
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- New Zealand Bill of Rights 1990
- Protection of Personal and Property Rights Act 1988
- *"Medical Law in New Zealand"*, Skegg Paterson Ed, 2006, Thomson Brookers.

Internal

- Cultural Policy
- Consent Policy
- Death of a Patient Policy
- Mercy Hospital Ethics Directives
- CPR Policy

Policy Processes

- All patients are regarded as being 'FOR RESUSCITATION' unless an explicit decision has been made in advance. If in doubt, RESUSCITATE.
- When an individual patient's clinical condition is such that active resuscitation will only defer their imminent death, the Health Professional is not under a duty to avert that death at all costs. In such circumstances, there must be a lawful reason for omitting to carry out resuscitation. Such a lawful reason must comply with accepted clinical standards and good clinical practice.

New Zealand law:

- Clearly requires that a patient be resuscitated where the procedure would be beneficial to him or her;
- Places a legal duty on Health Professionals to provide the necessities of life to patients (Section 151 of the Crimes Act 1961);
- States that necessary/reasonable treatment that is readily available may not be withheld or withdrawn from a competent patient against their will;
- 'NOT FOR RESUSCITATION' orders are not clearly defined in any one statute or case law within New Zealand however resuscitation does come under the Health & Disability Act (1993) and Health & Disability Commissioner- Code of Health & Disability Services Consumer Rights (1996) in NZ.

1. Standards for Resuscitation

- All patients are 'for resuscitation' in principle
- Unless an explicit decision has been made in advance, in accordance with Appendix I & II of this policy
- If in doubt, resuscitate
- Emergency Response Activation Systems
 - i. All staff working in any clinical service area must know the appropriate emergency procedures.

Making the 'Not For Resuscitation' Decision

The Credentialed Specialist has ultimate responsibility for:

- The provision of information to the patient/family/whanau about the 'Not for Resuscitation' decision.
- The documentation of a decision related to the patient's Resuscitation status.
- Resuscitation Decision Making Process Synopsis (Appendix III provides a synopsis).
- Ensuring that where the patient is not competent, key persons e.g. the family/whanau, may be consulted to assist in determining the patient's wishes, and their names and relationship to the patient identified and documented in the Clinical Record.

- The patient may have made an advance directive (see Definitions).
- Discussing NFR authorisation with patients and others (Appendix IV provides guidelines).
- Any staff discussion that intends to invoke an NFR authorisation should involve:
 - The patient's Credentialed Specialist
 - A suitably experienced nurse e.g. Clinical Coordinator/Shift co-ordinator
 - Other staff as appropriate.

Patient Initiated NFR

- The New Zealand Bill of Rights Act 1990, Section 11 states: *Everyone has the right to refuse any medical treatment.*
- All patients requesting NFR status must be given a copy of Guidelines for discussing 'Not for Resuscitation' (Appendix IV), and a senior member of the nursing staff or a credentialed specialist should be available to discuss the content with them.
- If a competent patient makes a free and informed request, not to be resuscitated, the request must be documented by the patient and the patient's Credentialed Specialist, on the 'Patient Initiated 'Not for Resuscitation' Authorisation Form' (see Appendix I) and in the patient's clinical record. (This is the equivalent of Informed Consent).
- Such a request should be current as determined by the patient and clinical team. The Credentialed Specialist has ultimate responsibility for this. A patient initiated NFR decision must be re-evaluated and re-documented;
 - on each inpatient admission (except where the patient is terminally ill and their NFR status has been deemed by the patient's Credentialed Specialist not to have changed); and
 - whenever the patient's health status alters.
- If there is not agreement 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 Credentialed Specialist responsible. Life saving treatment however may not be provided if a competent patient has given an informed and applicable refusal of consent.

Medically Initiated NFR

- When a patient approaches the end of any terminal process and death is anticipated, the staff responsible for the patient's care should review the appropriateness of the treatment plan, including decisions about resuscitation.
- No health professional is required to provide clinical treatment where it is not of benefit to the patient.

- There are circumstances in which the decision ‘Not for Resuscitation’ should be made in consultation with the patient’s key person(s). These circumstances include:
 - Where 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 clinical record by the patient’s Credentialed Specialist. It is recommended that this be countersigned by another clinical staff member.
 - Where the patient cannot make the decision and seeks to have the decision made for him/her.
 - Where the patient is incompetent e.g. because of a decreased level of consciousness.
- In all such cases, the Credentialed Specialist must:
 - Clearly identify the status of key persons and as far as possible verify that they are in fact the patient’s approved spokesperson/s.
 - Clearly identify for Maori the whanau spokesperson for the patient. Kaitiaki (guardianship model) can be used to assist in communication with whanau.
 - 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 Guidelines for discussing ‘Not for Resuscitation (Appendix IV) can be provided to the key person/s if it is felt it can help decision-making.
 - Ensure the patient’s cultural requirements are met as far as possible.
- Where there is conflict between key persons, they should be encouraged to meet and agree. If no agreement is reached, the Credentialed Specialist will decide in consultation with the clinical team. The Credentialed Specialist may access legal advice if needed from a legal advisor.
- Where a patient is an *incompetent adult* without a welfare guardian appointed, or for any patient where resuscitation is not clinically indicated, a ‘Medically Initiated Not for Resuscitation Authorisation Form’ (Appendix II) must be completed by the Credentialed Specialist.
- The topics listed on the ‘Medically Initiated Not for Resuscitation Authorisation Form’ must be discussed. Further guidance on topics that should be discussed with key persons may be found in Appendix IV ‘Guidelines for Discussing Not for Resuscitation Authorisations’.
- 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. This allows for key person/s to ask questions and clarify the situation.
- Signature of the ‘Medically Initiated Not for Resuscitation Authorisation Form’, by clinical staff indicates the information has been given or attempted to be given and the staff believe it was understood by the patient or family. In authorising a ‘Medically Initiated NFR Authorisation’, the Credentialed Specialist accepts responsibility for the non-performance of resuscitation.

- Where there is conflict between the Credentialed Specialist and the patient/guardian regarding an NFR decision, advice from Legal Advisor must be sought.

Documentation of the Patient's NFR Status

- The patient's NFR status may only be documented by the Credentialed Specialist.
- In all inpatient cases the decision not to resuscitate must be fully documented in the patient's clinical record on the appropriate NFR authorisation form. This ensures clarity of communication with other members of the clinical team, and also records information provided to key persons. This is necessary to make sure all staff are clear whether resuscitation is to be performed or not.
- Where partial resuscitation is indicated under certain circumstances (e.g. 'use of oxygen until family arrive', not to be intubated') this shall be clearly documented on the NFR form. Partial resuscitation should not be used if it causes the patient pain or discomfort.

Revoking a Not for Resuscitation Authorisation; A NFR should be reassessed as part of ongoing nursing evaluation of care

- If the patient wishes to revoke a 'Patient Initiated NFR Authorisation', or the Credentialed Specialist decides that a 'Medically Initiated NFR Authorisation' is no longer appropriate, then the NFR authorisation form must be ruled through diagonally in ink and endorsed CANCELLED. The endorsement must be dated and signed by the:
 - Credentialed Specialist, with the full name and designation of the Credentialed Specialist (or equivalent) stated; and
 - patient, in the case of the 'Patient Initiated NFR Authorisation'.

Reviewing a Not for Resuscitation Authorisation

- The Credentialed Specialist will be informed of changes in the patient's health status that are relevant to determining the appropriateness of continuing the NFR status
- The NFR decision must be re-evaluated and re-documented;
 - on each inpatient admission (except where the patient is terminally ill and their NFR status has been deemed by the patient's Credentialed Specialist not to have changed); and
 - whenever the patient's health status alters.

Treatment of Patients who are 'Not for Resuscitation'

- Patients who are NFR must still receive such treatment as deemed appropriate by the Credentialed Specialist and in consultation with members of the clinical tea.

