HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	**Department:** Legal Department	**Policy No.:** **PAT 0008**
		Revision No.: N/A
	Issued by: Regional Medical Directors	**Effective Date:** December 5, 2001
Subject: ***Corporate Policy on Do Not Resuscitate Orders***	**Approved by:** Thomas M. Driskill, Jr. President & CEO	**Supersedes Policy:** N/A
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I. PURPOSE: The purpose of this policy is to establish procedures to follow when decisions concerning Do Not Resuscitate (DNR) orders must be made. Patients who experience cardiopulmonary arrest will receive full resuscitation measures (full support), unless otherwise ordered and documented by the physician in the medical record.

II. DEFINITIONS:

A. DNR Order - The patient will receive medically appropriate therapeutic care, but only to the point of cardiac and respiratory arrest. At that point, cardiopulmonary resuscitation will not be initiated.

B. Attending Physician - Physician selected by or assigned to the patient who has assumed primary responsibility for the treatment and care of the patient. If such physician directs/requests another physician to assume primary responsibility, and such other physician accepts such primary responsibility, that person becomes the attending physician.

C. Full Support - Cardiopulmonary resuscitation, medication, cardioversion, intubation, and other life saving measures.

D. Terminal Condition - Any incurable or irreversible disease, illness, injury, or condition which, without the administration of life sustaining procedures, will, as a medical probability, result in death of the patient.

E. Life Sustaining Procedures - Any medical procedures or intervention, including the artificial provision of fluids, nourishment, medication, or other procedures, that when administered to a patient, will serve only to prolong the dying process, but does not include procedures necessary for patient comfort or relief.

F. Advance Directives (Living Will, Durable Power of Attorney, Other Directives) - A written declaration voluntarily, executed by the declarant in accordance with the requirements of HRS CHAPTER 327D-3.

G. Surrogate - A substitute decision maker for the patient. A designated representative of the patient who will work with the healthcare team in carrying out the wishes of the patient.

H. Competent Patient - A patient shall be considered to be competent if the patient is:

1. An adult, 18 years of age or older, or an emancipated minor; and
2. Conscious; and
3. Able to understand the nature and severity of the illness involved; and
4. Able to understand the possible consequences of alternatives to the proposed treatment; and
5. Able to make informed choices concerning the course of treatment.

I. Incompetent Patient - A patient shall be considered to be incompetent if the patient:

1. Is a minor (under 18 years of age, unless the patient is an emancipated minor); or
2. Is unable to understand the nature and severity of the illness involved; or
3. Is unable to understand the possible consequences of, and alternative to, the proposed treatment; or
4. Is unable to make informed and deliberate choices concerning the course of treatment; or
5. Has been declared legally incompetent by a court.

III. PROCEDURES:

A. Mechanism(s) for Reaching Decisions about the Withholding of Resuscitation Services from Individual Patients: This policy and procedure shall provide a framework for the decision making process recognizing the need to conform to the legal requirements of the hospital's jurisdiction.

1. Patient/Family for any Decision which Restricts Full Life Support Measures:

    a. If the attending physician determines that a DNR order is medically appropriate, the physician must then discuss the matter with the patient, if competent, explaining the basis for, and the consequences of, a DNR order.
    b. An adult patient with decision-making capacity generally may refuse any treatment unless the refusal will endanger the public health of an unborn child. The patient has a right to exclude having their family involved in the decision making process as the family has no legal right to be involved for a competent patient.
    c. After discussion, the patient must consent to the entry of a DNR order in their medical record. If the patient disagrees a DNR order may not be implemented.
    d. A directive made by an adult patient with decision-making capacity shall be honored after a loss of decision-making capacity if the patient is terminally ill or irreversibly unconscious. Family/legal representative (surrogate) should be consulted to assess the validity of the original directive except when a provider is available with personal knowledge of the patient's preferences.

2. Incompetent Patient:

   a. If the patient is incompetent, the attending physician must discuss the basis for, and consequences of a DNR order with the patient's next of kin/legal representative (surrogate) who is reasonably available.

   b. If the next of kin or legal representative (surrogate) is not available due to geographical distance or physical disability, the attending physician may obtain a consultation over the telephone.

   c. After fully explaining the medical condition and prognosis of the patient (with one [1] witness to the telephonic explanation and the conversation), the attending physician and the witness must document the outcome of the conversation in the patient's medical record. The documentation must include the name and relationship of the person consulted along with the date and time.

   d. If the next of kin/legal representative (surrogate) is not reasonably available, the attending physician shall obtain a second opinion from another physician with clinical privileges who shall also examine the patient and certify in the medical record the patient's condition.

3. "DNR" Orders do not authorize the withholding or withdrawal of comfort care, including pain medication. Pain medications can be withheld or withdrawn only from adults with decision-making capacity.

   The attending physician shall contact all consultants who have assisted in the case to inform them of the DNR order.

   The fact that a patient possesses an Organ Donor Card or has expressed a wish to donate his or her body under the Uniform Anatomical Gift Act shall not be a factor in classifying or evaluating the medical condition of the patient in the hospital. An Organ Donor Card activates certain steps only after the death of a patient has been ascertained. It does not determine the course of treatment during life.

4. Documentation of decisions reached and held in discussion with the patient and/or patient's surrogate, and closely involved consultant must be recorded in the progress notes in the patient's medical record by the attending physician.

   Documentation should also include an assessment of the patient's physical, cognitive, and emotional status including the patient's diagnosis, condition, prognosis, and treatment options.

B. Mechanism(s) for Resolving Conflicts in Decision Making Should They Arise: This policy and procedure recognizes that no single set of policies can anticipate the various situations in which difficult decisions about withholding resuscitative services will need to be made. This outlines the process for handling the resolution of conflicts should they arise.

1. When the physician disagrees with the patient and/or surrogate based on grounds other than the prognosis or diagnosis, arrangements shall be made by the attending physician to transfer the care of the patient to another physician. Documentation of the transfer shall be entered in the medical record, including the order sheet.

2. When the physician has questions about the patient's competency, psychiatric or other appropriate consultation should be sought.

3. If the decision is seriously questioned, action should be postponed while:

    a. The objections are considered to determine if they can be resolved.
    b. The respective procedural steps are followed to resolve conflicts.
    c. Staff with personal objections are assigned to other duties to the extent feasible.

4. Any patient, family, surrogate, physician, nurse, or other staff member should feel free to call questions to the attention of Administration.

    a. This is an extension of the nurse's legal responsibility to question apparently erroneous orders (including the apparently erroneous absence of orders) first by discussing it with the attending physician; and second, if still not satisfied, by bringing the concern to the attention of the nurse supervisor.
    b. If there is a question concerning who is the proper surrogate and/or surrogates cannot agree on a decision, mediation and counseling should be pursued. Treatment will be continued until a resolution is reached.
    c. Disagreement between the physician and patient or surrogate should be handled as outlined in paragraph B1, above. When disagreements focused on the diagnosis or prognosis, another or third, if necessary, medical opinion should be sought.

C. Roles of Physicians, Nursing Personnel, Other Staff Hospital Administration, and Family Members in the Decision to Withhold Resuscitative Services: This policy and procedure is to offer guidance to help professionals with the ethical and legal issues involved in such decisions and decrease the uncertainty about the practices permitted by the hospital.

1. Physicians - Using the mechanisms described above and after the decision has been reached to withhold resuscitative services from a patient, it is the attending physician's (or his/her designee's) responsibility to clearly write on the order sheet an order for "DNR" and any specified exceptions. These specified exceptions are intubation, direct cardioversion, antiarrhythmics, chest compression, and/or vasopressors. The order along with any exceptions shall be the foremost document in the medical record.

NO VERBAL ORDERS will be accepted except in emergencies when a physician who is present and rendering care may give an oral order which is soon thereafter put in writing by the ordering physician in the medical record.

The "DNR" order will carry an automatic seven (7) day termination for patients in Acute Care. At that time, the chart must be reviewed by the attending physician or his/her designee, and a new order written if the "DNR" status is to be continued.

2. Non-Physician Staff - It is not the primary role of the non-physician staff to raise the issue of resuscitation to family or the patient. Physicians, nurses and other staff will not withhold or withdraw treatment until after there is a written physician's order. Except in emergencies, the physician who is present and rendering care, an oral order may be given which is soon thereafter put in writing in the medical record by the ordering physician.

   A change in the patient's or surrogate decision regarding code status is to be reported to the attending physician promptly and documented in the chart. Nursing concerns about the level of treatment should be directed to the attending physician and the nurse supervisor, not the patient or family.

   The chart will be clearly marked with `DNR" and any specified exceptions to alleviate confusion if the patient is in an area of the hospital off the nursing unit.

   NOTE: Patients with a `DNR" status will be documented as such on x-rays, and other "off the unit" exam request under the heading of clinical information.

3. Governing Body Designate - The Governing Body designates the Administrator for establishing a "DNR" process in compliance with regulations of the State, Federal, JCAHO, and other regulatory agencies.

4. Ethics Committee - The Ethics Committee will be available for consultation at the request of any hospital employee, physician, patient, or surrogate involved in the decision making.

5. Quality Management Department - The Quality Management Department is delegated the responsibility to monitor the effectiveness of patient care within the context of these procedures once the decision has been made to withhold or limit the patient's treatment. Information from the monitoring activities will be included in the quality assurance activities of the respective medical staff and hospital departments with the findings and recommendations communicated through the hospital's quality management committee.

6. Family Members - Family members will be included in consultations with the patient to the degree practicable under the protection of the patient's right to privacy and taking into account the patient's wishes. The wishes of the patient regarding privacy

and the inclusion of family members in the decision making process will be respected at all times.

If consultation with the patient is impractical due to the patient's physical/mental condition, family members will be primary source of information to assist in the decision-making process.

D. Patient's Rights: Provisions to assure the rights of the patient are respected when decisions are made to withhold resuscitative services. This policy and procedure is designated to affirm the patient's responsibility for such decision making and sustain the patient's autonomy while assuring respect for the right of the patient. Living Will and Durable Power of Attorney for medical care and other directives are the most important documents to be considered in instructing a physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

E. Operative Do-Not Resuscitate (DNR) Clarification (Medical Patients): It is expected that the surgeon will accept primary responsibility for advising patients regarding risks and benefits when discussing a potential operation. Some patients with "DNR" status become candidates for surgical procedures that may provide them with significant benefit even though the procedure may not change the natural history of the underlying disease. The "DNR" status of said patients shall be maintained or rescinded during the operative period only after a collaborative discussion with the patient/family by the physician. This must be clearly documented in the medical record by the physician.

Attachment: 1. Operative Do-Not-Resuscitate (DNR) Clarification

Hawaii Health Systems Corporation
OPERATIVE DO-NOT-RESUSCITATE (DNR) CLARIFICATION

☐ This patient desires that the DNR directives already in place preoperatively be followed in the Operating Room and Post-Anesthesia Care Unit if, in the assessment and judgment of the attending surgeon and anesthesiology services, any clinical condition presents that in all likelihood is probably going to be irreversible. Clinical events believed, in the assessment and judgment of the surgeon and anesthesiology services, to be temporary and reversible are to be treated with resuscitative measures.

☐ This patient desires that all resuscitative measures be employed in the Operating Room and Post-Anesthesia Care Unit in all clinical situations that arise.

Attending Physician or Surgeon Signature	Date
Patient Signature or Health Care Power of Attorney or Legal Guardian, as applicable	Date