Algorithm for Informed Consent for a Plan of Treatment related to CPR and Completion of the DNR Confirmation Form

Grey Bruce Integrated Health Coalition
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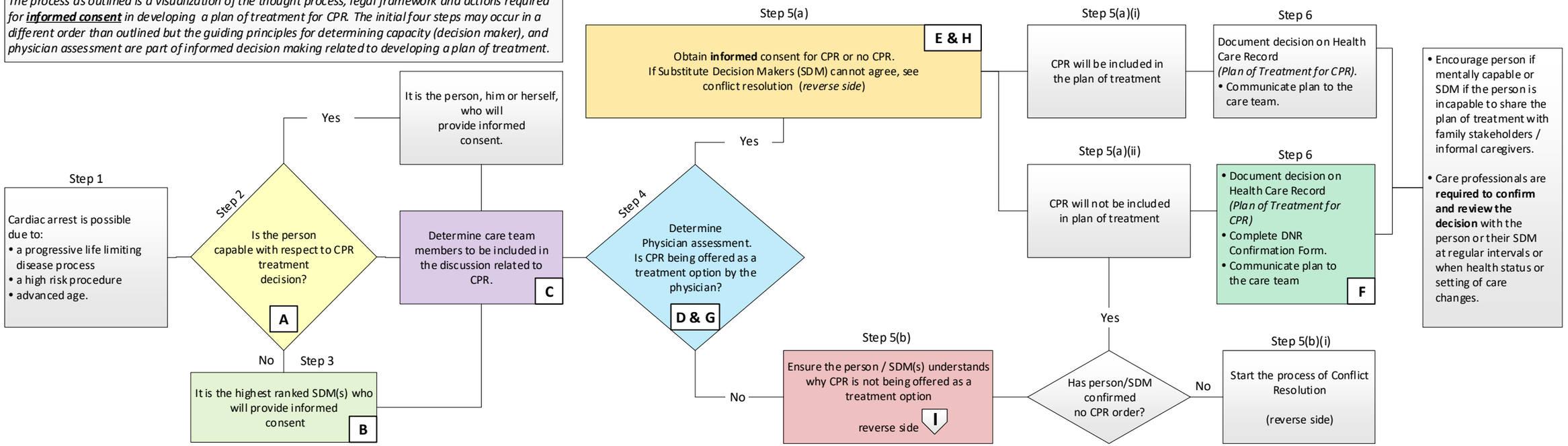
*The process as outlined is a visualization of the thought process, legal framework and actions required for **informed consent** in developing a plan of treatment for CPR. The initial four steps may occur in a different order than outlined but the guiding principles for determining capacity (decision maker), and physician assessment are part of informed decision making related to developing a plan of treatment.*



Capacity to Consent — A

Capacity is determined by the health care professional proposing the treatment.

A person is considered to be mentally capable with respect to the CPR treatment decision if:

a) the person is able to understand the information that is relevant to making a decision concerning the CPR Treatment

and

b) the person is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision regarding CPR treatment.

Hierarchy of Substitute Decision Makers (SDM) — B

- Guardian of the person
- Attorney in a POAPC with authority for treatment/admission decision making
- Representative appointed by the Consent and Capacity Board
- Spouse or partner
- Parent or child or Children's Aid Society
- Parent with Right of Access
- Brother or sister
- Any other relative by blood, marriage or adoption
- Office of the Public Guardian and Trustee

The SDM(s) must be: (a) Capable with respect to the treatment; (b) At least 16 years old, unless he or she is the incapable person's parent; (c) Not prohibited by court or separation agreement from having access to the incapable person or giving or refusing consent on his behalf; (d) Available; (a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal) and (e) Willing to assume the responsibility of giving or refusing consent

Role of SDM – ACP in Ontario: A Summary »
www.speakupontario.ca/resource/ace-tip-sheets/

CPR Discussion Planning — C

- Identify lead for team
- Identify health care team members who will participate in the meeting
- Identify those individuals the person (SDM if incapable) wishes to include in the information sharing and decision making process
- Ensure all participants are informed of the specifics of the meeting

Guiding Principles — D

Helping patient/SDM plan for EOL care (including discussion of CPR) involves:

- Understanding what is important to the person (goals of care)
- Communicating effectively and compassionately
- Providing pertinent medical and clinical information
- Clearly explaining palliative care and its focus of active care across all domains
- Being clear about outcomes and rationale for continuation or discontinuation of treatment or CPR
- Engaging continuously to review as health status and goals of care change

Reference:
College of Physicians & Surgeons of Ontario (CPSO) Policy - Planning for and Providing Quality End-of-Life Care September 2019

Elements of Consent — E

The consent must:
- relate to the treatment
- be informed
- be given voluntarily
- not be obtained through misrepresentation or fraud

Informed Consent

Informed consent means that:
(a) The person received information that a reasonable person in the same circumstances would require in order to make a decision about the treatment with respect to the nature of the treatment, expected benefits, material risks, material side effects, alternative courses of action and likely consequences of not having the treatment.
(b) The person received responses to his or her requests for additional information.

See H on reverse side for discussion points for obtaining informed consent for CPR.

DNR Confirmation Form — F

The DNR-C is a confirmation that there is a plan of treatment to not include CPR and that informed consent has been obtained.

The DNR-C directs paramedics and firefighters only and provides a directive when:
- 911 is called, or
- when the person is being transported by ambulance

The form belongs to the person and has a unique identification number. Copies of the most current DNR-C can be shared with all settings of care. Each setting of care is required to review, confirm and record informed consent to a treatment plan to not include CPR in their records. A replacement DNR-C form does not have to be completed for each setting of care if the decision to not include CPR remains the same

Patients and families are encouraged to present the form (or copy) to providers/ settings of care.

Algorithm for Conflict Resolution regarding CPR Decision

This conflict resolution process focuses on decisions related to CPR and includes potential outcomes related to the role of the SDM(s) and the Health Care Clinician if agreement can not be reached.

1. Document details of conflict and plan of action for conflict resolution on the health care record.

2. Consider the need for a second medical opinion, a palliative care team consultation, and/or ethical/legal consultation.

1. Convene a team family conference with a skilled neutral person as chair.
2. Explain the conflict resolution process to all parties. Acknowledge a hope for voluntary resolution. Share that the meeting is to provide support and information as well as an opportunity to share concerns and perspectives.
3. Negotiate the ground rules (time frames, respectful shared dialogue to explore the underlying meaning that supports the positions held by each party).
4. Review the required information for an informed discussion on CPR and share what the cardiac arrest event may look like with CPR and without CPR.
5. Bring new expert opinions to the table (e.g. physician second opinion, ethicist etc.)

Do all parties agree that CPR will not be included in the plan of treatment?

- Yes → Return to Algorithm Step 5(a)(ii).
- No → Physician decides whether to:
  - identify and correct any misinformation or misunderstanding
  - offer treatment in light of goals, values and beliefs of the person or SDM
  - facilitate offering a second opinion
  - transfer care to another facility or health-care provider. (last resort and only when all appropriate and available methods of resolving conflict have been exhausted)
  - seek the support of an ethicist or ethics committee as appropriate and available
  - apply to Consent and Capacity Board (CCB) for review and determination of SDM actions in accordance with patients wishes or best interests

Have 2 or more equally Ranked SDMs come to a unanimous agreement?

- Yes → Return to Algorithm Step 5(a)(i) or Step 5(a)(ii).
- No → Contact the Office of the Public Guardian and Trustee (OPGT)
  (Treatment Decision Unit)
  London: *(Mon-Fri)* 1-800-891-0504, ext. 2002 or 1-519-660-3145
  or
  Toronto: *Urgent weekends and stat holidays only* 1-800-387-2127.

If equal ranking SDM's cannot agree, then the Healthcare Practitioner must turn to the OPGT for the decision.

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Discussion on CPR can take place:
- as early as possible in the person's illness
- when there is a change in the person's medical status
- when there are no further treatment options
- when there is a move to or transition to certain settings of care (LTC, residential hospice, ICU/CCU, etc.)

When offering CPR:
- Must involve patient and/or SDM
- Must obtain informed consent (unless during emergency)
- Must be clear about outcomes that would influence initiation, continuation or discontinuation

No CPR order:
- Must not be unilateral decision regarding no-CPR order
- Must inform the patient and/or SDM of the reasons why a no-CPR order will be written
- If the patient or SDM disagrees, engage in the conflict resolution process (no order written until resolved)
- If cardiac or respiratory arrest occurs while resolution is underway, provide resuscitative efforts required by standard of care

Decisions may change over time and these decisions must be reviewed with patient and/or SDM on changing condition/circumstances

** Refer to the CPSO EOL policy for more details and current updates

H

CPR Discussion Points when CPR is being offered as a treatment option

1. Explain the goal is to respect the person's informed choice and to share accurate information, planning for appropriate care. Include discussion on the person's unique values and goals, and review the current medical information.

2. Explain what CPR is and include: process (setting dependent), compressions, mouth to mouth, electric shocks, intravenous medications, intubation/ventilation, etc.

3. Explain what is involved in CPR and that:
   - How well CPR works depends on the health of the person (share information such as the CareNet – CPR Decision Aid for Patients and Their Families)
   - CPR is an aggressive procedure and will not improve the illness that caused the heart stoppage.
   - CPR requires someone trained in CPR to be on hand immediately and the emergency call out to paramedics with the hospital emergency actions. Chances of survival depends on the health of person and location of person when they arrested (i.e. home versus ICU) General rates of survival in chronic illness range from 2 to 10% with a 50% chance of requiring to live in a care facility. Benefits of CPR are virtually zero for those who suffer an unwitnessed heart stoppage.
   - CPR will not help those who are at the natural end of their lives due to a progressive life limiting illness.
   - Informed consent discussions may differ slightly by setting, e.g. In hospital CPR more specific options can be offered.

4. Discuss the:
   Benefits:
   - In optimal circumstances CPR can save life

   Risks:
   - After 5 minutes without a heartbeat, serious brain and organ damage takes place which can leave the person in a state of pain and dependent on machines which breathe for the person. Breathing machines require a tube about the size of one's thumb to be placed into the person's airway. Tubes in the airway prevent the person from being able to talk while the machine is breathing for him or her. Depending on the severity of the brain damage, the machine for breathing may not be able to be removed.

   Possible side effects:
   - Broken ribs
   - Punctured lung
   - Pain from trauma to chest
   - Possible brain injury such as memory loss, speech problems or paralysis (approximately 25% to 50% of survivors)

   Alternative courses of action:
   - Excellent care and appropriate medical interventions that respect the person's goals related to comfort, prolonging life, and which address physical, emotional and spiritual needs will be offered.

   Consequences of not having CPR:
   - Palliative support will be given as natural death occurs.

5. Answer any questions. Identify and correct any misunderstanding or misinformation.

6. Discuss the Physician Assessment related to CPR (Box G).

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CPR Discussion Points when no CPR Order is being considered by physician

1. Follow Steps 1 to 6 in Box H.

2. Inform and share assessment with the person/SDM that CPR would not be beneficial and could cause harm. Explain that the physician is recommending that CPR not be included in the plan of treatment.

3. Answer any further questions but do not continue to press your points.

4. If the person/SDM agrees with the physician's recommendation/decision, refer to Algorithm Step 5(a) (ii).

5. If the person/SDM does not agree with the physician's recommendation/decision, refer the person to the physician for further conversation (conflict resolution algorithm may be a helpful framework)

References

- College of Nurses - Consent Practice Guideline 2017
- College of Physicians & Surgeons of Ontario (CPSO) Policy - Planning for and Providing Quality End-of-Life Care September 2019
- Ontario Health Care Consent Act, 1996
- Ontario Substitute Decisions Act, 1992
- CareNet Cardio Pulmonary Resuscitation (CPR): A Decision Aid for Patients and Their Families – retrieved » www.speakupontario.ca, February 2017
- Do Not Resuscitate Confirmation: Reference Document for Paramedics, Firefighters, Nurses & Physicians, May 2007, Version 13.1