

### Resuscitation Review Tool: Part B

Q.	Insert collated responses here	This information is derived from the <i>Resuscitation, Revised 1999</i> practice standard; the <i>Coroners Act, R.S.O. 1990, c. C.37</i> ; <i>Health Care Consent Act, 1996, S.O. 1996, c. 2</i> ; and the <i>Vital Statistics Act, R.S.O. 1990, c. V.4</i> .
1.		<p>The nurse is knowledgeable about practice-setting policies, including those specific to resuscitation. The nurse assesses their congruence with the College’s practice expectations and identifies, advocates for and/or participates in any indicated revisions.</p> <p>Do Not Resuscitate (DNR) policies can be helpful if they are accurate and reflect information relating to the resuscitation issues referred to in legislation. The legislative acts relevant to this issue are:</p> <ul style="list-style-type: none"> <li>• <i>The Coroners Act</i>;</li> <li>• <i>The Health Care Consent Act, 1996</i>; and</li> <li>• <i>The Vital Statistics Act</i>.</li> </ul> <p>Other reference documents include <i>Resuscitation, Revised 1999</i> and other College practice standards.</p>
2.		<p>There is no legislative requirement for a physician’s DNR order (written or oral) when the nurse knows the client’s wish for no resuscitation.</p> <p>Section 5 of the <i>Health Care Consent Act, 1996</i> states:</p> <p><b>Wishes</b></p> <p><u>5.</u> (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).</p> <p>Manner of expression</p> <p>(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).</p> <p>Later wishes prevail</p> <p>(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).</p> <p>If the practice setting has a policy that requires a DNR order, the nurse should advocate for a review/discussion of that policy.</p>

3.		<p><b>The Ministry of Health and Long-Term Care’s definition of cardiopulmonary resuscitation (CPR):</b>  <i>CPR is an immediate application of life-saving measures to an individual who has suffered sudden respiratory or cardiorespiratory arrest. These measures include basic cardiac life support involving chest compressions, and/or artificial ventilation, such as mouth-to-mouth resuscitation, bagging, and where available, defibrillation, intubation and other procedures the Heart and Stroke Foundation of Ontario considers advanced cardiac life support procedures.</i></p> <p>Using this definition of CPR fosters consistency across all practice settings and enables all health care practitioners, including unregulated health care providers such as paramedics, to provide a consistent approach when performing CPR. This eliminates potential conflict. For example, a client may believe that CPR is just chest compressions. However, because paramedics must follow the ministry’s definition of CPR, if the client experiences an arrest while being transferred in an emergency medical services ambulance to another facility, the paramedics would initiate components the client did not think was included in CPR.</p>
4.		<p>Nurses use their professional judgment to determine whether they need to discuss the client’s resuscitation wishes with the client.</p> <p>When it is anticipated that the client will not require resuscitation, the nurse is not expected to ask the client about his or her wishes. If the client voluntarily communicates such information, the nurse must document it.</p> <p>When it is anticipated the client will require CPR, it is expected that the nurse will:</p> <ul style="list-style-type: none"> <li>▪ identify the client’s wishes regarding resuscitation;</li> <li>▪ document the resuscitation wishes and communicate them to the health care team;</li> <li>▪ review the resuscitation wishes;</li> <li>▪ advocate on behalf of the client; and</li> <li>▪ implement the client’s wishes.</li> </ul>

5.		<p><b>Treatment in an emergency (treatment without consent)</b>  Section 25(1) of the <i>Health Care Consent Act, 1996</i> states: “There is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.”  Treatment can be given without consent in an emergency situation.</p>
6.		<p><b>Do not initiate basic CPR if:</b></p> <ul style="list-style-type: none"> <li>▪ the client’s wish for no resuscitation is known to the nurse through personal communication, an advance directive or other documentation (the client’s wish for no resuscitation is followed even in the absence of a physician’s written DNR order as this is not legally required);</li> <li>▪ the incapable client’s wish is not known and the substitute decision-maker has identified that she or he does not wish resuscitation for the client;</li> <li>▪ the attending physician has informed the client that CPR will not be of benefit and is not part of the treatment plan. In this situation, the nurse is not obligated to perform CPR even if the client or family requests it; or</li> <li>▪ the client exhibits obvious signs of death (vital signs absent plus rigor mortis, tissue decay, etc.).</li> </ul>
7.		<p>There is no legal definition of pronouncing death.</p>
8.		<p>All nurses can pronounce an expected death in all practice settings. In long-term care, the coroner must be called after every 10 deaths.</p>
9.		<p><b>The Vital Statistics Act under Section 21 states:</b></p> <p><b>Medical certificate of death</b>  (3) Subject to subsections (3.1) and (4), any legally qualified <u>medical practitioner</u> who has been in attendance during the last illness of a deceased person or who has sufficient knowledge of the last illness shall forthwith after the death complete and sign a medical certificate of death in the prescribed form, stating the cause of death according to the classification of diseases adopted by reference in the regulations, and shall deliver the medical certificate to the funeral director or other person in charge of</p>

	<p>the body. R.S.O. 1990, c. V.4, s. 21 (3); 1997, c. 9, s. 7 (1).</p> <p><b>Same</b></p> <p>(3.1) In the prescribed circumstances, a prescribed person shall, immediately <u>after the death</u> of a person, <u>complete and sign a medical certificate of death</u> in the prescribed form stating the cause of death according to the classification of diseases adopted by reference in the regulations and shall deliver the medical certificate to the funeral director or other person in charge of the body. 1997, c. 9, s. 7 (1).</p> <p><b>Coroner’s case</b></p> <p>(4) In the case of a death of which the coroner is required to be notified under section 10 of the <i>Coroners Act</i>, the coroner notified shall, as soon as the cause of death is known, complete and sign a medical certificate of death in the prescribed form, stating the cause of death according to the classification of diseases adopted by reference in the regulations, and shall deliver the medical certificate to the funeral director or other person in charge of the body.</p> <p>Registered Nurses in the Extended Class (RN [EC]) also known as Nurse Practitioners (NPs), can certify an expected death. The <i>Resuscitation, Revised 1999</i> practice standard states: “Certifying death means determining the cause of death and signing the Medical Certificate of Death. There is a legal requirement for a physician or RN(EC) to certify death.”</p>
10.	<p>Nurses do not legally require a physician’s order to pronounce a death when the death is expected. According to the <i>Resuscitation, Revised 1999</i> practice standard, “When clients are expected to die and their plans of care do not include resuscitation, nurses have the knowledge, skill and judgment to determine that death has occurred and the ability to pronounce death.”</p>
11.	<p>Section 2 of the <i>Health Care Consent Act, 1996</i> defines a plan of treatment as a plan that:</p> <ol style="list-style-type: none"> <li>a) is developed by one or more health practitioners;</li> <li>b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person’s current health condition; and</li> <li>c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person’s current health condition;</li> </ol>

12.		<p>A power of attorney is a legal document that gives someone else the right to act on your behalf. In Ontario, there are three kinds of power of attorney:</p> <ul style="list-style-type: none"> <li>▪ A continuing power of attorney for property covers your financial affairs and allows the person you name to act for you even if you become mentally incapable.</li> <li>▪ A power of attorney for personal care covers your personal decisions, such as housing and health care.</li> <li>▪ A non-continuing power of attorney for property covers your financial affairs but cannot be used if you become mentally incapable. For example, you might give this power of attorney if you need someone to look after your financial transactions while you are away from home for an extended period.</li> </ul> <p>Making a power of attorney is voluntary. No one can be forced to make one.</p> <p><b>Substitute Decision-Maker</b>  The substitute decision-maker is the person authorized to give or refuse consent on behalf of an incapable client. The decision-maker may be a relative or a specially appointed person, such as someone with power of attorney for personal care. The substitute decision-maker must understand that the decisions she/he makes must represent the wishes of the incapable client and not their own.</p>
13.		<p><b>Advance Directive</b>  An advance directive is “the means used to document and communicate a person’s preferences regarding life-sustaining treatment in the event that they become incapable of expressing those wishes for themselves.”</p>
		<b>Disagreeing with the multidisciplinary plan of care</b>

14.		For more information, refer to the College's <i>Disagreeing with the Multidisciplinary Plan of Care</i> practice guideline, available at <a href="http://www.cno.org/docs/prac/41017_fsDisagreeing.pdf">www.cno.org/docs/prac/41017_fsDisagreeing.pdf</a> .
15.		<p><b>Documenting and communicating the client's wishes</b>  Although documentation routines vary across practice settings, nurses within a specific practice setting can promote efficient and effective care by employing a consistent method and location for documenting in client charts the client's wishes and resuscitation status.</p> <p>For more information, refer to the College's <i>Documentation</i> practice standard available at <a href="http://www.cno.org/docs/prac/41001_documentation.pdf">www.cno.org/docs/prac/41001_documentation.pdf</a></p>
16.		<p><b>Presenting to the emergency room with a treatment plan that includes "No CPR"</b>  The client's wish for no resuscitation should be documented and shared with the health care team members. The client's wish not to be resuscitated should be reflected in the treatment plan and respected when the client is transferred from one setting to another. A documented DNR as part of the treatment plan from another facility reflects the client's wish for no resuscitation, in which case nurses would not provide CPR. As part of ongoing care, the client's wishes should be confirmed with the client or substitute decision-maker of the incapable client.</p> <p><b>Note: The Do Not Resuscitate Confirmation</b> form is not a plan of treatment. It is a communication tool to direct emergency medical services and firefighters. It reflects that a treatment plan exists in which DNR is part of the plan or resuscitation is deemed to be of no benefit and is not part of the treatment plan.</p>
17.		<p><b>Capable</b>  A client is considered capable when she or he is able to 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.</p>

