POLICY

Number: 7311-60-016
Title: Resuscitation Policy

Authorization

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Source: Chair(s) SHR/SCA Joint Ethics Committee, Physician Lead (Pediatrics Department), and Director(s), Seniors’ Health and Continuing Care
Cross Index: 7311-60-005, 7311-60-004
Date Approved: June 3, 2015
Date Revised: February 11, 2016
Date Effective: February 29, 2016
Date Reaffirmed:
Scope: SHR and Affiliates

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OVERVIEW

This policy is meant to address uncertainties surrounding resuscitation discussions, resuscitative decisions and interventions undertaken in the Saskatoon Health Region (SHR) and its affiliates. The policy is intended to clarify the terminology used during resuscitation discussions with patients/residents and members of the health care team to ensure clarity of meaning. It provides guidance for health care providers who are involved in highly complex, often emotional resuscitation discussions, decisions and interventions.

DEFINITIONS

**Advance Care Directive** or **Health Care Directive** is a legally binding document written by a person with capacity that is in effect when that person loses capacity. A health care directive provides direction regarding medical interventions and sometimes is referred to as a living will. Under The Health Care Directives and Substitute Health Care Decision Makers Act any individual 16 years of age or more with capacity has the right to make an advance care directive for themself.¹

**Advanced Cardiac Life Support (ACLS)** means (and usually includes) airway management, chest compressions, assessment of abnormal heart rhythms, and re-establishment of normal heart rhythms with external defibrillation (electrical shock) and intravenous medications. Pediatric Advanced Life Support (PALS) is similar to ACLS, but intended for the pediatric age group. The employment of these various techniques is case-specific and can vary significantly from case to case. ACLS and PALS is only provided by trained medical personnel.

**Basic Life Support (BLS)** means interventions immediately employed when cardiopulmonary arrest has occurred. BLS can be provided by trained medical personnel or by trained laypersons. BLS does not include the use of drugs or invasive procedural skills.

**Best interests** means applying the principles of beneficence and non-maleficence in decision making. Conceptions and understanding of the term ‘best interests’ may differ between individuals. For the purpose of this policy best interests are based on clinical standard of practice.

**Beneficence** means to act beneficently toward others (contribute to the welfare of others, which may include preventing harm, removing harm, promoting well-being, or maximizing good).

**Capacity** means the ability to understand information relevant to a health care decision, the ability to appreciate the reasonably foreseeable consequences of making or not making a health care decision, and the ability to communicate the decision².

**Cardiopulmonary Resuscitation (CPR)** means an emergency intervention to restore blood flow in the event of cardiac arrest, with the aim of keeping the person alive until advanced medical care arrives. It involves chest compressions and may also include rescue breathing or mouth-to-mouth breaths in order to provide oxygen to the heart and brain.³

**Clinically indicated cardiopulmonary resuscitation** may include one or more of the following:

1. For licensed health care professionals it is in accordance with their clinical standard of

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¹ The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s. 3
² The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan
³ Heart and Stroke Foundation of Canada Position Statement: Cardiopulmonary Resuscitation
practice.

2. The arrest has been witnessed or is known/ judged to be very recent (e.g. there has not been more than a few minutes lapse since the patient/resident was observed living) and there is no clear clinical contraindication to resuscitation.

3. The Resuscitation Care Plan, the Serious Illness-Sudden Collapse Plan, or an existing Advance Care Directive documents that resuscitation will be attempted or a patient/resident with capacity has requested resuscitation.

**Conflict of Interest** occurs when an individual in a position of responsibility or trust has competing professional or personal interests that potentially may interfere in carrying out his/her responsibilities (fiduciary duties). Conflict of interest (actual, potential, or perceived) must always be disclosed (see SHR policy: Conflict of Interest).

**Designate(s)** is a health care professional who is a member of the health care team and has knowledge of resuscitative interventions and the patient’s/resident’s medical condition.

**Fiduciary duties** arise from the legal or ethical relationship of confidence or trust between two or more parties. Fiduciary duties of Health Care Providers include acting in good faith, having loyalty towards the patient/resident and never placing their own personal interest over the patient’s/resident’s (self-effacement).

**Hands only CPR** means delivering high quality chest compressions by pushing hard and fast on the center of the chest. Hands only CPR is provided by only untrained staff or laypersons.

**Health Care Providers and or professionals** means person(s) who has/have a provider-patient/resident relationship based on ethical, fiduciary and employment duties towards the patient/resident. While health care professionals are considered health care providers, they are licensed to provide treatment and have a defined scope of professional practice mandated by their professional organization and have a code of ethics. Whereas, health care providers may not necessarily be licensed by a professional organization or have a code of ethics to adhere to.

**Mature Minors** are individuals who have not reached the age of majority, but have capacity to make health care decisions for themselves. There is no minimum age limit in Saskatchewan to make health care decisions. Therefore, Individuals younger than 18 years of age with capacity may make health care decisions for themselves.

**Minors** are individuals who have not reached the age of majority (18 years of age)⁴.

**Most Responsible Physician (MRP)** means:

- In acute care, the physician named on the patient’s chart, as the attending physician or the physician most responsible for the patient’s care.
- In Special-care Home(s), the MRP is the family physician, contract physician or the physician appointed for the resident’s care.

**Non-maleficence** means “first do no harm”. Harms should not outweigh the benefits (harms versus benefits assessment should be undertaken in a decision making process).

**Other Locations** means all sites where SHR staff work except acute care and Special-care Home(s). Examples include, but are not limited to, Avord Tower, SHR Laundry, Home Care, Alvin Buckwold Child Development Program, West Winds, Shaw Centre, and Field House.

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⁴ The Age of Majority Act, Saskatchewan s. 2(1).
Patient/resident includes client.

Respect for autonomy means respecting people’s right to self-determination or self-governance such that their views, decisions and actions are based on their personal values and beliefs.

Resuscitation means the process of attempting to revive a patient from apparent death or unconsciousness by means of CPR, BLS, ACLS/PALS and/or other available resuscitative interventions.

Resuscitation Care Plan means a physician’s order form used in acute care for documenting specific actions to be taken by health care providers in the event a patient suffers cardiac and/or respiratory arrest. It does not replace an Advance Care Directive.

Serious Illness-Sudden Collapse Plan (SI-SC Plan) means a care plan used in Special-care Home(s), which is also applicable in acute care. This document may be designated as:
- An Advance Care Directive only when completed by a resident with capacity.
- An advance instruction of a substitute health care decision maker(s) or two treatment providers when resident lacks capacity and is made according to the known wishes of the resident or best interests where wishes are unknown.

Special-care Home(s) means a long-term care home.

Substitute health care decision maker(s) means an appropriate substituted decision maker who is appointed by patient/resident or the court to make health care decisions, determined in accordance with The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan. Substitute health care decision maker(s) include:
- Proxy means an individual(s) appointed by a person with capacity. Proxies must be 18 years of age or older and have capacity and must make decisions according to the patient’s prior wishes, or in the patient’s best interests if the patient’s prior wishes are unknown or unclear.
- Power of attorney generally refers to financial and/or personal decisions. Personal decisions usually do not include a right to make treatment decisions (health care decisions) for a patient/resident unless specifically stated by a phrase appointing the person as a substitute health care decision maker (e.g. proxy). In this case the person appointed as power of attorney is also the proxy.
- Substitute decision maker (SDM) is an individual who is the nearest relative of the patient/resident who has been given legal authority to make health care decisions for a person without capacity when a proxy has not been appointed. Substitute decision maker(s) must be 18 years of age or older, willing, available and have capacity and must make decisions according to the patient’s prior wishes, or in the patient’s resident’s best interests if the patient’s resident’s prior wishes are unknown or unclear.
- Parent(s) means an individual(s) who make decisions based on the best interests of the minor child (unmarried and less than 16 years of age and without capacity). A parent could be:
  (i) the mother of a child;
  (ii) the father of a child;
  (iii) a person to whom custody of a child has been granted by a court of competent jurisdiction or by a deed or agreement of custody.

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5 The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s.16(4)
6 The Child and Family Services Act, Saskatchewan
(iv) a person with whom a child resides and who stands in loco parentis to the child;

- **Guardian(s)** means an individual(s) who has been granted legal custody (not physical custody) of the child and decides based on best interests of the minor child (unmarried and less than 16 years of age and without capacity). 7

- **Personal guardian or personal co-decision maker or temporary personal guardian** means an individual(s) appointed by the court for a person who lacks capacity and is greater than 18 years of age and decides based on prior known wishes or in the patient’s best interests, if the patient’s prior wishes are unknown or unclear. 8, 9

- **Public guardian and trustee** means an individual who is a public official acting as a personal guardian appointed by the Lieutenant Governor in Council for a person who lacks capacity and is greater than 18 years of age and decides based on prior known wishes or in the patient’s best interests, if the patient’s prior wishes are unknown or unclear. 10, 11

**Support Natural Death** means to allow the dying process to occur as comfortably as possible without the use of aggressive interventions that might only serve to prolong the dying process.

**Treatment** means anything that is done for a therapeutic, preventative or palliative purpose related to the physical or mental health of a person.

**Treatment providers** mean persons authorized by law to provide treatment12 (health care professionals) and authorized to complete the Resuscitation Care Plan/SI-SC Plan, as part of their professional scope of practice. This could be MRP, Physician, medical resident, registered nurse or licensed practical nurse, nurse practitioner, etc. Any person may provide CPR regardless of whether they are licensed providers or have training.

**Unwitnessed Arrest** means an arrest that occurs when a patient’s heart is not being monitored and when there is no one present to observe or notice the cessation of breathing or to check for a pulse.

1. **PURPOSE**
   
   The purpose of this policy is to establish SHR’s requirements and accountability regarding the use of CPR and/or other resuscitative interventions.

2. **PRINCIPLES**

   2.1 This policy assists patients/residents or substitute health care decision maker(s) and health care team(s) achieve a high quality decision that is informed (evidence informed and values informed), is reasonable and justifiable (ethically and or legally) and promotes quality of life during the dying process. Health care providers in their decision making should always uphold SHR’s values of respect, compassion, excellence, stewardship, and collaboration and uphold their professional Code of Ethics in the delivery of a patient/resident centered care service.

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7 The Child and Family Services Act, Saskatchewan
8 The Adult Guardianship and Co-decision-making Act, Saskatchewan
9 The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan
10 The Adult Guardianship and Co-decision-making Act, Saskatchewan
11 The Public Guardian and Trustee Act, Saskatchewan
12 The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s. 1(i)
2.2 Goals of care discussions (including resuscitation when clinically appropriate) should occur as soon as reasonably possible after admission to acute care, move in to a Special-care Home(s) or transfer as diagnoses and prognoses are often initially uncertain. Health care providers discuss Resuscitation Care Plans/SI-SC Plans and resuscitative options with patients/residents or substitute health care decision maker(s).

2.3 “Slow Codes” are unethical and will not be practiced in SHR facilities or Special-care Home(s). Slow Codes involve health care providers going through the motions of attempting resuscitation without serious intention of succeeding. This harms the patient’s dignity and the public’s trust.

2.4 Patients/Residents have the right to choose (informed consent/informed refusal) whether to receive CPR interventions and to specify the circumstances under which they might choose to limit its use. Substitute health care decision maker(s) also have the right to choose resuscitative interventions where this is consistent with the known wishes of the patient/resident. Patients/residents with capacity have the right to change or review their choices at any time and may include family members or support persons of their choosing in any discussion(s).

2.5 Patients/residents not wanting resuscitation or patients/residents for whom resuscitation is not clinically indicated are entitled to all other appropriate medical interventions, regardless of whether they suffer from terminal illnesses or are near death. Do not call a code does not mean do not treat.

2.6 Health care providers have ethical duties and fiduciary duties towards their patient’s/resident’s, based on the health care provider-patient relationship. The fiduciary duties of a health care provider are to always act in the best interest of their patient’s/resident’s, regardless of their capacity to make health care decisions or their age (e.g. children). Health care providers must always consider the harms and benefits of all interventions they provide or choose not to provide to their patient’s/resident’s. Harms should not outweigh the benefits in either situation. Health care providers may be required to balance competing principles of respect for autonomy, beneficence and non-maleficence.

2.7 Health care professionals should only attempt resuscitation when it is clinically indicated\(^\) (see definition). When it is not clinically indicated resuscitation should not be offered. While consent is required only when resuscitation is offered transparency is essential. Therefore, the rationale for not offering resuscitation should be disclosed with the patient/resident or substitute health care decision maker(s). Health care professionals should remain cognizant of the perceived power imbalance between provider and patient/resident and public expectations. In the absence of strong medical evidence, where benefits are uncertain, health care professionals should favour offering resuscitation.

3. POLICY

3.1 Resuscitation Plans - Acute Care and Special-care Home(s)

\(^{13}\) The Canadian Medical Association Policy: CMA code of Ethics (Updated 2004) s. 23
3.1.1 The term “DNR” (Do Not Resuscitate) is an antiquated term that is not recognized in SHR and will not be used.

3.1.2 SHR authorizes and encourages the use of Resuscitation Care Plans by MRP/Designate(s) in acute care and SI-SC Plans in Special-care Home(s).

3.1.3 Patient’s/Resident’s goals of care, values, beliefs, religious practice and expectations of treatment will be explored before completing the Plan. This may be a multi team approach involving the MRP/Designate(s), social work, spiritual care (including elders), First Nations and Métis Health Service, etc.

3.1.4 Resuscitation Care Plans in acute care shall be discussed as soon as reasonably possible within 24 hours of admission for all patients for whom resuscitative interventions may eventually be considered based on goals of care.

3.1.4.1 MRPs complete the Resuscitation Care Plan or may identify a designate(s) who accepts this role.

3.1.4.2 Resuscitation Care Plans are not to be carried over from one acute care hospital admission to the next.

3.1.4.3 Plans regarding resuscitation will be discussed during each acute care hospital admission and whenever the patient’s medical condition changes significantly, unless the decision has already been made by the patient to decline resuscitation regardless of diagnosis or prognosis.

3.1.4.4 Resuscitation Care Plan shall be discussed with mature minors.

3.1.5 SI-SC Plans for residents in Special-care Home(s) shall be discussed as soon as reasonably possible and completed within eight weeks of move in.

3.1.5.1 Manager(s)/Director(s) of Care identify designate(s) to assist in the completion of SI-SC Plans.

3.1.5.2 The SI-SC Plan shall be reviewed annually, when there are significant changes in the resident’s health or when the resident requests under the following circumstances:

- A resident with capacity agrees or requests the review.
- As requested by the substitute health care decision maker(s) when the resident lacks capacity and does not have an advance care directive.

3.1.5.3 The use of a form to make an Advance Care Directive is not a requirement. No person is obliged to make a health care decision and therefore, residents with capacity at Special-care Home(s) may choose not to complete the SI-SC Plan.

3.1.6 Resuscitation Care Plans/SI-SC Plans should be consistent with an existing Advance Care Directive.

3.1.6.1 If the patient/resident with capacity makes a decision inconsistent with an existing Advance Care Directive then the existing Advance Care Directive must be updated by the patient/resident (handwritten changes are acceptable where the patient/resident initials, signs and dates relevant section(s)).

- At Special-care Home(s) a new SI-SC Plan should be completed by the resident with capacity to reflect the changes.

3.1.7 Copies of the Resuscitation Care Plan and/or SI-SC Plan and the most recent Advance Care Directive, when available, must accompany...

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\textsuperscript{14} The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s. 10
patients/residents during transfers between acute care and Special-care Home(s).

3.1.7.1 At acute care patient’s chart containing these documents must always accompany the patient when being moved within acute care for the purpose of treatment/diagnostics.

3.1.7.2 SHR does not support the use of visual cues or identifiers for the purpose of identifying patients/residents who wish or do not wish to be resuscitated (the chart must be referenced). If patients/residents voluntarily use a “Full Code or No CPR Bracelet/Necklet” then their wishes will be respected.

3.2 Resuscitation Decisions

See Principle 2.4.

3.2.1 The patient/resident or substitute health care decision maker(s) must be informed that limiting components of CPR may reduce the likelihood of the success of the intervention. The potential effect of limitations must be discussed with the patient/resident and documented.

3.2.2 In the event a patient/resident or substitute health care decision maker(s) imposes limitations such that the attempted resuscitation will certainly or almost certainly be unsuccessful, the MRP has the right to decline attempting resuscitation. The MRP must inform the patient/resident or substitute health care decision maker(s) of the reason for the decision.

- The MRP/Designate(s) must document the discussion in the progress notes and any limitations on resuscitative interventions requested by the patient/resident in the Resuscitation Care Plan/SI-SC Plan (an addendum page may be added to the SI-SC Plan).

3.2.3 If the patient/resident or substitute health care decision maker(s) insist that resuscitation be undertaken and the MRP believes it is not clinically indicated, every reasonable effort will be made to transfer the patient’s/resident’s care to an another MRP willing to honor patient’s/resident’s or substitute health care decision maker(s) request, where possible (see procedure Withholding of Resuscitation Treatment).

4. ROLES AND RESPONSIBILITIES

4.1 MRP/Designate(s)

4.1.1 Explore patient/resident goals of care, values, beliefs, religious practice and expectations of treatment prior to completing Resuscitation Care Plans/SI-SC Plans. Provide patients/residents and families the Resuscitation Brochure.

4.1.2 In acute care discuss and complete the Resuscitation Care Plan with patients and confirm with them their documented code status.

4.1.3 At Special-care Home(s) Designate(s) discuss and assist in the completion of the SI-SC Plan.

4.1.4 In acute care MRP or the physician directing the code blue/outreach provides the notification of death to family. This task will not be delegated to junior residents or medical students and is best done with the MRP.

4.1.5 Special-care Home(s) Manager(s)/Director(s) of Care or Designate(s) provide the notification of death to family.

4.1.6 At Other Locations notification of death to family if present is provided by paramedics, registered nurse/licensed practical nurse, or physician, police/coroner as applicable.
4.2 Health Care Team – Acute and Special-care Home(s) and Other Locations

4.2.1 Initiate resuscitation discussions based on goals of care and provide patients/residents and families the Resuscitation Brochure.
4.2.2 Document resuscitation discussions that take place and advise the MRP.
4.2.3 Request patients/residents to provide their most recent Advance Care Directive.
4.2.4 Ensure the copies of the Resuscitation Care Plan and or SI-SC Plan and the most recent Advance Care Directive, when available, accompany patients/residents during transfers between acute care and Special-care Home(s).
4.2.5 During transport, inform EMS/First Responders/code blue/outreach teams of patient/resident’s wishes regarding resuscitation.
4.2.6 After a cardiac arrest SHR staff at Other Locations are to inform their Manager(s) whether or not resuscitation was provided.

4.3 Patients/Residents and or Substitute Health Care Decision Maker(s)

4.3.1 Provide the MRP/Designate(s) or the health care team their Advance Care Directive and advise the health care team if they use a “No CPR Bracelet/Necklet”.
  ➢ Encourage individuals to place their Advance Care Directive on or in the refrigerator to permit easy access by paramedics and or other SHR staff if called to the homes.
4.3.2 In Special-care Home(s) Residents or substitute health care decision maker(s) complete the SI-SC Plan with the assistance from the MRP/Designate(s).

4.4 Ethics Consultants/Bioethicists

4.4.1 Respond to ethics consultation requests involving resuscitation (see SHR Policy: Ethics Consultation Service).

5. POLICY MANAGEMENT

The management of this policy including policy education and monitoring is the responsibility of Managers in Acute Care and Manager(s)/Director(s) of Care in Special-care Home(s).

The implementation is the responsibility of the MRP/Designate(s) and health care providers.

Amendments are the responsibility of the Vice President, Practitioner Staff Affairs, Vice President Integrated Health Services and Chair(s), SHR/SCA Joint Ethics Committee.

6. NON-COMPLIANCE/BREACH

Non-compliance with this policy may result in disciplinary action up to and including termination of employment and/or privileges.

7. REFERENCES

See end of procedure.
1. PURPOSE

The purpose of this procedure is to:

1.1 Establish the processes to be followed when faced with various decisions related to resuscitation.

1.2 Establish a process for resolution of circumstances where patients/residents or substitute health care decision maker(s) and MRP’s disagree about resuscitation.

2. PRINCIPLES

2.1 All resuscitation discussions with patients/residents or substitute health care decision maker(s) are to reflect a positive atmosphere of caregiving and reflect SHR’s value of respect, compassion, excellence, stewardship, collaboration.

2.2 Communication will aim to elicit goals of care. These discussions will be open and sensitive to the patient’s/resident’s culture, language, goals, values and religious beliefs and practice. Coercive or misleading statements must not be used, however, known risks and likely outcomes should be carefully outlined.

2.3 A shared decision making process should be used where decisions are made collectively between the patient/resident or the substitute health care decision maker(s) and the MRP/Designate(s). “By encouraging a constructive dialogue with patients, physicians can foster an environment that supports effective decision-making, which is central to patient-centred care. In this way, patients become empowered to actively manage their health condition and the associated care plan. This often leads to better health outcomes for patients. This approach to communication, also known as “shared decision-making,” treats the patient as an expert in their own life and circumstances. It fosters the development of plans which reflect an understanding of the patients’ views, life, and cultural experiences, and healthcare goals. In this model of communication, clinical information is exchanged rather than unilaterally imposed. This encourages a meaningful discussion of the patient’s condition, treatment options, outcomes, and uncertainties.”

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16 Canadian Medical Protective Association: Helping patients make informed decisions, April 2014
3. PROCEDURE

3.1 Discussion of Resuscitation Care Plans and SI-SC Plans

Within 24 hours of patient admission to acute care or as soon as reasonably possible for residents moving into a Special-Care home, the healthcare providers will offer patients/residents an opportunity to discuss resuscitation related to their goals of care. Any team member may discuss resuscitation with patients/residents and inform the MRP/Designate(s). These discussions shall always be documented in progress notes.

3.1.1 Information concerning the actual interventions used during resuscitation and their likelihood of success will only be provided by those with adequate knowledge and training, including knowledge of the patient’s/resident’s medical condition.

3.1.2 Ask the patient/resident or healthcare decision maker(s), if there is an Advance Care Directive. If there is an advance care directive, request and retain a copy.

3.1.3 Encourage patients/residents to discuss the Resuscitation Care Plan/SI-SC Plan with those who will be their healthcare decision maker(s) when they lack capacity.

3.2 Completion of Resuscitation Care Plans/SI-SC Plans

3.2.1 Resuscitation Care Plans shall be completed as soon as reasonably possible within 24 hours of admission for all patients for whom resuscitative interventions may eventually be considered based on goals of care.

3.2.1.1 In acute care after completion of the Resuscitation Care Plan the MRP/Designate must immediately inform the patient with capacity or the substitute health care decision maker(s) when the patient lacks capacity of the documented code status.

3.2.1.2 In acute care designate(s) must immediately inform the MRP regarding the Resuscitation Care Plan, if they have completed and signed the Resuscitation Care Plan.

3.2.1.3 Resuscitation Care Plans shall be recompleted after discussions with the patient where a minor attains capacity during the acute care admission.

3.2.2 For all Special-care Home(s) residents, an SI-SC Plan shall be completed as soon as reasonably possible and completed within eight weeks of move in.

3.2.2.1 If resident does not wish to complete an SI-SC Plan, the MRP or Designate(s) informs the resident that In the event of a cardiopulmonary arrest where wishes are unknown resuscitation will be offered when clinically indicated.

3.2.2.2 Staff assist by providing or sending a copy of the SI-SC Plan to the designated healthcare decision maker(s) when requested by the patient/resident.

3.2.3 Refer to the following documents prior to completion of the Resuscitation Care Plans/SI-SC Plans, as appropriate:

3.2.3.1 Advance Care Directives, where available
3.2.3.2 SI-SC Plan at acute care, where available.
3.2.3.3 Resuscitation Care Plan at Special-care Home, where available.
3.2.4 Where the patient/resident lacks capacity MRPs/Designate(s) should consider whether the patient/'s/resident’s family physician may have a better understanding of the patient/'s/resident’s wishes and expectations regarding resuscitation, along with a better sense of their life-long values.

- With the substitute health care decision maker(s) permission, MRP/Designate(s) should consider asking the family physician to be involved in resuscitation discussions with patients/residents.

3.3 Incorrect Completion of Resuscitation Care Plans/ SI-SC Plans of Patients/ Residents who lack capacity

3.3.1 If there is evidence to indicate that the Resuscitation Care Plan or the SI-SC Plan (designated as an advance instruction) of the substitute health care decision maker(s) does not correctly reflect the wishes of the patient/resident, and there is no disagreement between physician and patient/resident wishes, then:

- MRP/Designate(s) marks the Resuscitation Care Plan or SI-SC Plan as void.
- MRP/Designate(s) creates a new Resuscitation Care Plan or SI-SC Plan after discussions with substitute health care decision maker(s) when patient lacks capacity. This discussion and documentation should take place at the earliest possible time.

3.3.1.2 In the event of a delay in discussions with substitute health care decision maker(s) where correct wishes are made known through an Advance Care Directive, follow the Advance Care Directive.

3.3.2 If the SI-SC Plan is designated as an Advance Care Directive and the evidence indicates that it was not correctly completed, then follow the intent of the document until discussions with resident take place and the document is corrected.

- An example of an incorrectly completed Advance Care Directive would be when it has been witnessed by a person appointed as the proxy or the proxy’s spouse when the patient/resident with capacity is physically unable to sign for themselves.\(^{17}\)

3.3.3 If the SI-SC Plan is designated as an Advance Care Directive, and it contradicts any pre-existing Advance Care Directive, then the most recent Advance Care Directive (SI-SC Plan in this case) must be followed.

3.4 Resuscitation Decisions at Acute Care and Special-care Home(s)

\(^{17}\) The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s.23
See Principle 2.4

3.4.1 **Patient/Resident has capacity**

3.4.1.1 Patients/residents may decline cardiopulmonary resuscitation verbally or in writing. The request of a patient/resident with capacity not to be resuscitated must be respected regardless of provider’s desires to attempt resuscitation.

- Circumstances can arise where health care providers may feel moral distress with patient’s/resident’s decision. Ethics may be contacted in these situations.

3.4.1.2 Regarding resuscitation and other health care decisions of patients/residents who have capacity, they have the right to transfer decision-making authority to another person(s) who have capacity.

3.4.2 **Patient/Resident does not have capacity**

3.4.2.1 When a patient/resident lacks capacity to make a health care decision, a substitute health care decision maker(s) have the right to make decisions in accordance with The Health Care Directives and Substitute Decision Makers Act, Saskatchewan.

- Substitute health care decision maker(s) may accept or decline resuscitation on behalf of a patient/resident. This decision must be based on the prior known wishes of the patient/resident or best interests where wishes are unknown.

- Circumstances can arise where health care providers may feel moral distress with healthcare decision maker(s) decision. Ethics may be contacted in these situations.

3.4.2.2 If the patient/resident lacks capacity and does not have a substitute healthcare decision maker (i.e. no proxy or nearest relative), then two treatment providers will make Resuscitation Care Plan/SI-SC Plan decisions and complete the forms.

- The treatment provider believes that the proposed resuscitation decision is needed and in the best interest of the patient/resident.

- A second treatment provider must agree with the decision and both must document their decision.18

3.5 **Placement of Documents**

3.5.1 In acute care the most recent Resuscitation Care Plan is to be inserted under the ‘Directives’ tab of the patient’s chart (if there is an Advance Care Directive, attach to the Resuscitation Care Plan). The Resuscitation Care Plan must always be the first document under the directives tab.

- When a new Resuscitation Care Plan is completed the old Resuscitation Care Plan must be clearly marked as void and placed in the patient’s overflow chart. If there is no overflow chart, then the voided Resuscitation Care Plan shall be placed in the health records discharge basket for health records to collect. The voided Resuscitation Care Plan must not be placed in the patient’s chart.

- If a copy of the SI-SC Plan accompanied the patient from Special-care Home(s), then it should be placed under the ‘Directives’ tab of

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18 The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s. 16(4):
the resident’s chart, until a Resuscitation Care Plan has been discussed and completed.

3.5.2 In Special-care Home(s) the most recent SI-SC Plan is to be inserted under the ‘Directives’ tab of the resident’s chart (if there is an Advance Care Directive, attach to the SI-SC Plan). The SI-SC Plan must always be the first document under the directives tab.

- When a resident with capacity creates a revised SI-SC Plan, then the resident should mark the old SI-SC Plan as void and it should be placed in an overflow chart.
- The voided SI-SC Plan should not be placed in the resident’s chart.
- If a copy of the Resuscitation Care Plan accompanied the resident from acute care, it should be placed under the ‘Directives’ tab of the resident’s chart, until an SI-SC Plan has been discussed and completed.

3.5.3 Advance Care Directives in acute care, Special-care Home(s) and Other Locations are placed under the ‘Directives’ tab of the patient’s/resident’s chart.

3.5.4 In acute care and at Special-care Home(s) the Checklist for Contested Resuscitation Decision must be placed in patient’s/resident’s progress notes section.

4. **Resuscitative Interventions at Acute Care, Special-care Home(s) and Other Locations**

**4.1 Witnessed Cardiac Arrests - Acute Care, Special-care Home(s) and Other Locations**

Resuscitation will be attempted as soon as possible when a patient/resident suffers a witnessed cardiac arrest. In most cases of cardiopulmonary arrest, resuscitation will be attempted except when:

4.1.1 The patient/resident has explicitly declined resuscitative interventions verbally or in writing or substitute health care decision maker(s) decline resuscitative interventions where this is consistent with the known wishes of the patient.

4.1.2 When it is not clinically indicated.

**4.2 Unwitnessed arrests - Acute Care, Special-care Home(s) and Other Locations**

Management of unwitnessed arrests in patients/residents whose heart is not being monitored requires that a decision be made by the health care providers first arriving at the scene.

4.2.1 This decision includes how recently the cardiac arrest occurred and if cardiopulmonary resuscitation is clinically indicated.

- If a health care provider is unable to determine whether cardiopulmonary resuscitation is clinically indicated and qualified health care professionals are not immediately available to assist in this determination, then the default position is to attempt resuscitation.
- The code blue/outreach teams, 9-1-1 emergency medical services dispatcher or the paramedics may make the final determination.

4.2.2 If it is evident that considerable time has passed since the arrest occurred (for example, the body is pulseless, breathless and cold (algor mortis), or there is appreciable stiffness (rigor mortis), or there is visible body discoloration (livor mortis), health care providers are legitimately entitled to withhold resuscitation attempts.
No punitive action shall be initiated against providers making such judgments in good faith.

If doubt exists or providers disagree on how to proceed after initial assessment, the default position is to attempt resuscitation.

As with all other arrests, resuscitation should not be initiated if the patient/resident or substitute health care decision maker(s) has declined this intervention.

### 4.3 Wishes are unknown in Acute Care, Special-care Home(s) and Other Locations

#### 4.3.1 In an emergency situation when resuscitation is clinically indicated

4.3.1.1 When a Resuscitation Care Plan/SI-SC Plan has not yet been discussed, the patient’s wishes are unknown, the patient has not specifically declined resuscitation and resuscitation is clinically indicated, resuscitation shall be attempted.

- If a health care provider is unable to determine whether cardiopulmonary resuscitation is clinically indicated and qualified health care professionals are not immediately available to assist in this determination, then the default position is to attempt resuscitation.

- The code blue/outreach teams, 9-1-1 emergency medical services dispatcher or the paramedics may make the final determination.

4.3.1.2 Resuscitation will be attempted in cardiopulmonary arrests involving staff and visitors at Special-care Home(s), acute care and other locations, when clinically indicated. All steps will be taken to facilitate delivery of necessary medical care and interventions.

### 5. Resuscitative Interventions - Special-care Home(s) and Other Locations

#### 5.1 Resuscitative interventions will be provided at Special-care Home(s) and other locations.

5.1.1 For residents who have indicated personally or by substitute health care decision maker(s) that they desire resuscitation, as documented on their SI-SC Plan, staff will call 9-1-1, when clinically indicated.

- Health care providers who are BLS or ACLS/PALS certified may initiate CPR and those not BLS or ACLS/PALS certified will implement hands only CPR and carry out instructions from the Emergency Medical Services Dispatcher to the best of their ability.

- Individuals not familiar with hands only CPR will call 9-1-1 and carry out instructions from the Emergency Medical Services Dispatcher to the best of their ability.

5.1.2 A barrier device shall be used when providing mouth to mouth resuscitation.

5.1.3 Where available an Automated External Defibrillator (AED) shall be used.

#### 5.2 Special-care Home(s) that are integrated with acute care may call code blue/outreach services, where available.

#### 5.3 Hands only CPR is a lay person’s standard and applies only to those individuals

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19 Government of Saskatchewan, Program Guidelines for Special Care Homes (April 2013), Section 15.7
who are not trained in CPR. Health care professionals trained in CPR must adhere to the standards taught in their CPR education.

6. **Withdrawing of Resuscitation Treatment - Acute Care, Special-care Home(s) and Other Locations**

   6.1 It is ethically justifiable to terminate resuscitative interventions when:

   6.1.1 Resuscitation efforts have been started and staff/code blue/outreach team learn that there is a Resuscitation Care Plan/SI-SC Plan or Advanced Care Directive indicating that the patient/resident does not wish to be resuscitated, then:

   6.1.1.1 Stop resuscitation interventions.

   6.1.1.2 Report this as an adverse event and flag for Ethics and Patient Safety (call Safety Alert System at 306-655-1600). (see SHR Policy: Critical Incident Reporting).

   6.1.1.3 Make a disclosure to substitute health care decision maker(s).

   6.1.2 Continuation of resuscitation is not clinically indicated, as determined by a licensed health care professional where it is in accordance with their clinical standard of practice.

   6.1.3 Situations where attempt to perform resuscitation would place the rescuer at risk of serious injury or mortal peril.

   6.1.4 Situations where the rescuer providing resuscitation is unable to continue due to exhaustion and where no other person is able to take over the resuscitation attempt.

   6.1.5 On the advice of the 9-1-1 emergency medical services dispatcher, paramedics, code blue team or outreach team.

7. **Withholding of Resuscitation Treatment - Acute Care and Special-care Home(s)**

   7.1 **Prior to an MRP concluding that resuscitation attempts should be withheld**

   7.1.1 A clinical assessment of the patient/resident must be performed by the MRP.

   7.1.2 The MRP will discuss with patients/residents with capacity or their substitute health care decision maker(s) (when patients/residents lack capacity), their prognosis, wishes for treatment and anticipated outcomes of treatment. The MRP will explore the patient’s/resident’s goals, values, beliefs and religious practice, and expectations of treatment with the substitute health care decision maker(s) before concluding that resuscitation should be withheld.

   7.1.3 The MRP will consider:

   7.1.3.1 Seeking assistance from other members of the health care team.

   7.1.3.2 A consult to the Palliative Care Team can be offered when appropriate.

   7.1.3.3 Where available, patients/residents and families should receive offers of assistance from social work, spiritual care (including elders), First Nations and Métis Health Service, and grief counseling services to assist with psychosocial, cultural, spiritual and informational needs.

   7.2 **Where the MRP concludes that resuscitation should be withheld**

   See Principles 2.6 and 2.7
7.2.1 The MRP will discuss withholding resuscitation with the health care team and develop consensus before moving forward with the decision.

7.2.2 The MRP will advise the patient/resident or substitute health care decision maker(s) of their decision in person, but will continue to offer resuscitation.

7.2.3 MRP discusses with the patient/resident or substitute health care decision maker(s) the rationale for withholding resuscitation treatment and attempt to reach consensus. Document this rationale in physician’s progress notes.
  - Describe palliative care measures which emphasize patient/resident comfort and dignity.

7.2.4 MRP offers and assists the patient/resident or substitute health care decision maker(s) in seeking a second opinion.
  - The physician providing a second opinion must not have a conflict of interest.

7.2.5 Document all pertinent details of the decision, its rationale and all communication with the patient/resident or substitute health care decision maker(s) regarding this decision in the patient’s/resident’s chart.

7.3 **When the resuscitation decision is contested**

While team members may disagree with a resuscitation decision, only the MRP may contest the patient’s/resident’s or substitute health care decision maker(s) decision using the following process. The MRP will:

7.3.1 Continue to offer resuscitation. Follow the steps in the **Checklist for Contested Resuscitation Decision** at acute care or Special-care Home(s).

7.3.2 Explore why the patient/resident or substitute health care decision maker(s) wishes treatment to be continued and address these issues directly.
  - Document in progress notes all communication that takes place with the patient/resident or substitute health care decision maker(s).

7.3.3 Involve Ethics Consultation Service early in these discussions.

7.3.4 Inform the patient/resident or substitute health care decision maker(s) that the health care team is attempting to find another physician who has no objection to honoring the patient’s/resident’s wishes.
  - It is the responsibility of the MRP to search for another physician who would be willing to honor the patient’s/resident’s request and accept the care of the patient/resident.

7.3.5 Obtain an opinion from a second qualified physician.
  - Physician(s) providing second opinions have a duty to remain objective and should avoid conflicts of interest.
  - Where a conflict of interest is present, in relation to providing such an opinion, such as the presence of a personal relationship, or based on personal values, beliefs, culture or other issue, it should be declared to the physician department head who may seek advice on its management from an ethicist.

7.3.6 Both physicians document in progress notes.

7.3.6.1 If both the MRP and the second physician disagree on the code status, then the MRP must transfer the patient/resident responsibilities to the physician who does not have an objection to honoring the patient’s/resident’s request.
  - This could include exploring admitting the patient/resident under another physician at a different facility.
7.3.7 If both the MRP and the second physician agree on the code status (i.e. unable to transfer the care to second physician) and a demand or request for treatment remains, the MRP will:

7.3.7.1 Involve Ethics Consultation Service, if not already done so.
7.3.7.2 Involve SHR's legal counsel.

7.3.8 Where despite all reasonable efforts, consensus cannot be reached the MRP may withhold resuscitation treatment after;

7.3.8.1 The MRP obtains approval from physician department head in writing agreeing with the MRP's decision.
   - Physician department head may delegate authority to physician division head, where applicable, to act on their behalf when resuscitation decision is contested and where the division head is more aware of the uniqueness and complexity of the clinical issue.
   - In circumstances where the MRP is the department head, then he/she may escalate to the Senior Medical Officer (Vice President, Practitioner Staff Affairs) for his/her approval in writing.

7.3.8.2 The MRP provides at least 96 hours (four days) advance written notice in person to the patient/resident or substitute health care decision maker(s) with the assistance of SHR Legal Counsel.

7.3.8.2.1 The notice must be signed by both the MRP and their physician department head or the Senior Medical Officer, where necessary.
   - The physician department head advises the responsible administrative VP for operational purposes.
   - The administrative VP shall inform the CEO.

7.3.8.2.2 During the 96 hours (four days) the MRP and all health care team members must continue to offer resuscitation.

7.3.9 Inform the patient/resident or substitute health care decision maker(s) in writing and in person of their option to approach the courts to obtain an injunction, which may include a joint application to the court for direction.

7.3.9.1 If patients/residents or their families do not have resources to seek legal advice, then SHR may facilitate access to community legal resources for a legal opinion.

7.3.9.2 After the completion of 96 hours:
   - do not call a code
   - follow court order (if applicable).

7.3.9.3 Recomplete Resuscitation Care Plan or the SI-SC Plan with patient/resident or healthcare decision maker(s) to reflect current code status.

8. Providing support to family - Acute Care and Special-care Home(s) and Other Locations

8.1 Staff provide support to family members during resuscitation and after unsuccessful resuscitation attempts.
   - Staff should receive support as well from Manager(s).

8.2 Family members may be present during resuscitation provided the patient/resident has not previously objected to it.

8.2.1 Whenever possible staff should accompany/support family members during resuscitation.
8.3 Notifying family members of the death of a loved one should be performed compassionately, taking into consideration culture, language, values and religious beliefs and practice. See Roles and Responsibilities section for notification of death.

9. Surgery and Anesthesiology - Acute Care

See Principle 2.4 and 2.6.

9.1 Patients or substitute health care decision maker(s) have the right to continue to decline (informed refusal) cardiopulmonary resuscitation during surgery in the event of a cardiac arrest. However, the implications of such a decision must be thoroughly discussed in the context of informed consent with the patient or their substitute health care decision maker(s) before the surgery begins.

- Conversations with the patient are to occur before the surgery is booked. The surgeon and or anesthesiologist will inform the patient of any likely negative surgical/anesthetic consequences associated with foregoing resuscitative interventions intraoperatively.
- Resuscitation decisions must be clearly documented between the surgeon and the anesthesiologist in the patient’s chart’s progress notes section.
- Resuscitation decisions must be clearly communicated between the surgeon and the anesthesiologist and all relevant staff prior to the surgery.

9.2 In the event a patient or substitute health care decision maker(s) imposes cardiopulmonary resuscitative limitations such that the attempted surgical/anesthetic intervention will certainly or almost certainly be unsuccessful, the surgeon and or anesthesiologist has the right to decline offering surgical/anesthetic intervention.

- The surgeon and or anesthesiologist discusses with the patient or substitute health care decision maker(s) the rationale for not offering surgical/anesthetic intervention and attempt to reach consensus. Document this rationale in physician’s progress notes.
- If the patient or substitute health care decision maker(s) insist that the surgical intervention/anesthetic intervention should be undertaken by the surgeon and or anesthesiologist, every reasonable effort will be made to transfer the patient’s care to an another surgeon and or anesthesiologist willing to honor the patient or substitute health care decision maker(s) request, where possible.
- If the issue remains unresolved consult Ethics Consultation Services.

10. Palliative Care in Acute Care

The goals of palliative care near the end of life are more consistent with adequate symptom management, supportive care and interventions that will improve quality of life, comfort and support natural death, rather than the use of certain aggressive interventions that might only serve to prolong the dying process.

10.1 The care of palliative patients in acute care facilities represents a special circumstance. Even though “Call a Code” capabilities exist within the hospital, the Regional Palliative Care Unit is entitled to draft protocols that clearly state CPR and ACLS/PALS will not be provided to patients and that emergency health care professionals will not be contacted.
10.2 As with other hospitalized patients, palliative care patients will be provided with the opportunity to discuss resuscitation in a sensitive and respectful manner.  
- Resuscitation Care Plans for such patient’s will be completed.

11. Resuscitation Training on Patients by Health Care Professionals - Acute Care

11.1 With expectation of recovery:
   
11.1.1 It is ethically justifiable for trainees (with considerable theoretical and practical training) to attempt lifesaving techniques (including resuscitation) under supervision of an experienced physician at a teaching hospital.  
- The process allows for development of skill for the next generation of health care professionals and also ensures delivery of quality service to the patient/resident.

11.2 With no expectation of recovery or on the recently deceased:
   
11.2.1 It is unethical for healthcare provides to practice or teach lifesaving techniques (including resuscitation) on patients with no expectation of recovery or the recently deceased, for the benefit of the trainee. Prolonging resuscitation for this purpose only serves to prolong the dying process for the patient and does not serve their interests.  
- This practice does not respect the dignity of the patient and undermines the family’s trust.  
- Respect for the recently deceased and their family should prevail over the need for healthcare providers to practice lifesaving techniques.

12. Research - Acute Care and Special-care Home(s) and Other Locations

12.1 Research on patients/residents while undergoing resuscitation may only be conducted with protocols that have been approved by the University of Saskatchewan Research Ethics Board and have received SHR Operational Approval (see SHR Policy: Research).

12.2 It is unethical to prolong resuscitative efforts solely for the purpose of completing research protocol. It does not respect the dignity of the patient/resident and undermines the family’s trust. The respect for the patient/resident and their family will prevail over the need for research.

13. PROCEDURE MANAGEMENT

The management of this procedure including procedure education and monitoring is the responsibility of Managers in Acute Care and Manager(s)/Director(s) of Care in Special-care Home(s).

The implementation is the responsibility of the MRP/Designate(s) and health care providers.

Amendments are the responsibility of the Vice President, Practitioner Staff Affairs, Vice President Integrated Health Services and Chair(s), SHR/SCA Joint Ethics Committee.
14. **NON-COMPLIANCE/BREACH**

Non-compliance with this procedure may result in disciplinary action up to and including termination of employment and/or privileges.

15. **REFERENCES**

29. Senn JS. Writing "no-CPR" orders: Must resuscitation always be offered? CMAJ 1994; 151(8):1125-1128
33. Prystajecky M, Lee T, Stewart S, Ward H. Resuscitation status documentation in adult patients admitted to a clinical teaching unit. Poster session presented at: Canadian Conference on Medical Education: Accountability from Self to Society; 2015 Apr 16-19; Vancouver, BC.

16. **Position Statements:**

5. Heart and Stroke Foundation of Canada Position Statement: Cardiopulmonary resuscitation (CPR)
   http://www.heartandstroke.bc.ca/site/c.kpIPKXOyFmG/b.4680057/k.408B/Position Statements__Cardiopulmonary_Resuscitation_CPR.htm

17. Saskatchewan Legislation:
   1. The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan
   2. The Child and Family Services Act, Saskatchewan
   3. The Adult Guardianship and Co-decision-making Act, Saskatchewan
   4. The Public Guardian and Trustee Act, Saskatchewan
   5. The Age of Majority Act, Saskatchewan

18. Government of Saskatchewan, Ministry of Health:
    Program Guidelines for Special Care Homes (April 2013)

19. Saskatoon Health Region Long Term Care Guidelines:
    Welcome Guide to Long Term Care Communities, 2014

20. Code of Ethics:
    1. CMA Code of Ethics (Updated 2004)
    2. Code of Ethics for Registered Nurses

21. SHR Policies:
    1. Code Blue Adult/Pediatric
    2. Advance Care Directives
    3. Critical Incident Reporting
    4. Ethics Consultation Service
    5. Research
    6. Responding to Unwell/Injured Individuals on Hospital Grounds
    7. Conflict of Interest
I shall be engaged in decision-making, as long as I have capacity to make my health care decisions. This document comes into effect ONLY during times when I lack capacity, and thereafter my proxy(s) or substitute decision maker must be engaged in the decision making process. I have the right to choose not to complete this plan.

### Section A

**In the event I have a serious illness or sudden collapse and am unable to communicate my wishes during this time. This section is in effect.**

**Should I experience a serious illness or sudden collapse** (Initial one option):
- [ ] Support my natural death.
- [ ] ONLY provide medical interventions available at this long term care home.
- [ ] Transfer me to the hospital

**If my heart stops beating or I stop breathing** (Initial one option):
- [ ] Do **NOT** call 911. Support my natural death.
- [ ] Call 911, begin CPR and transfer me to hospital.

### Section B

**In the event I have a permanent loss of capacity and have a serious illness or sudden collapse. This section is in effect.**

**Should I experience a serious illness or sudden collapse** (Initial one option):
- [ ] Support my natural death.
- [ ] ONLY provide medical interventions available at this long term care home.
- [ ] Transfer me to the hospital.

**If my heart stops beating or I stop breathing** (Initial one option):
- [ ] Do **NOT** call 911. Support my natural death.
- [ ] Call 911, begin CPR and transfer me to hospital.

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**Instructions for Physician for Section B:**
1. Section A will no longer be in effect when section B is signed & dated by the physician.
2. Physician signature indicates that the resident has permanently lost capacity.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Physician</th>
<th>Date</th>
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</table>

**Instructions for resident with capacity who completed this Advance Care Directive:**
1. Date, sign & write your name below, if you are physically able to.
2. If you are physically unable to sign, then another person may complete this plan and sign on your behalf. The signature of this person must be witnessed. The witness must also sign.
3. A person appointed as a proxy or a proxy’s spouse cannot sign as a witness.¹

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of Resident</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of the person who is signing on my behalf</th>
<th>Date</th>
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<tr>
<th>Name</th>
<th>Signature of Witness</th>
<th>Date</th>
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**Instructions:**

1. Complete the appropriate box and initial the appropriate statements.
2. Attach any pre-existing Advance Care Directive to this plan.
3. Staff should refer to the Resuscitation Policy for details or any clarifications.

### Resident with capacity to complete. This is an Advance Care Directive.

- [ ] I have an Advance Care Directive, which has been provided to this long term care home. It reflects my current wishes and should be attached to this plan.
- [ ] The contents of this plan are consistent with my pre-existing Advance Care Directive.
- [ ] I do not have a separate Advance Care Directive. Therefore, this plan is my Advance Care Directive.
- [ ] I choose not to complete this plan. (Staff should refer to the policy for direction).

### Proxy to complete when resident lacks capacity: This is an Advance Instruction.

- [ ] I am a proxy decision maker and this plan has been completed to align with the resident’s pre-existing Advance Care Directive.
- [ ] I am a proxy decision maker and this plan has been completed based on the resident’s prior known wishes.
- [ ] I am a proxy decision maker and this plan has been completed based on the resident’s best interests, because the resident’s wishes are unknown.

### Substitute decision maker to complete when resident lacks capacity AND there is no proxy. This is an Advance Instruction.

- [ ] I am the substitute decision maker and this plan has been completed to align with the resident’s pre-existing Advance Care Directive.
- [ ] I am the substitute decision maker & this plan has been completed based on the resident’s prior known wishes.
- [ ] I am the substitute decision maker and this plan has been completed based on the resident’s best interests, because resident’s wishes are unknown.

### Two treatment providers to complete when resident lacks capacity AND does not have a proxy or substitute decision maker (i.e. no nearest relative). This is an Advance Instruction.

- [ ] This plan has been completed by two treatment providers.

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2 The Health Care Directives and Substitute Health Care Decision Makers Act, 1997, s. 16(4)
NOTE: If in the medical opinion of a physician or nurse, an illness or collapse of an individual who lacks capacity appears to be treatable at a local hospital (e.g. the resident fell and suffered a fractured hip), then the resident will be transferred to the hospital for treatment. The proxy(s)/substitute decision maker will be contacted as quickly as possible about this decision. The proxy(s)/substitute decision maker will be responsible for any further treatment decisions.

There may be times when care that is in your or your loved one’s best interest cannot be provided in the home (e.g. pain or other symptoms are unable to be managed). In these instances, a transfer to the hospital may occur.

In the event of choking staff will attempt to remove the obstruction, but if choking results in cardiac arrest and the wishes of the resident are to not call 911, then natural death would be supported.

Determination of a Substitute Decision Maker:

Document in resident’s chart all discussions pertaining to consent or informed refusal. If there is no proxy and the resident lacks capacity, then health care professionals should work with the family to identify one nearest relative substitute decision maker based on the list below. This substitute decision maker should complete this plan. The substitute decision maker must be 18 years or older, willing, available and have capacity.

1. The spouse or person with whom the person requiring treatment cohabits and has cohabited as a spouse in a relationship of some permanence.
2. an adult son or daughter (eldest is preferred in all categories).
3. a parent or legal guardian
4. an adult brother or sister
5. a grandparent
6. an adult grandchild
7. an adult uncle or aunt
8. an adult nephew or niece

Instructions for resident with capacity:

1. If you select more than one proxy, then identify if they are joint or successive.
   - **Joint proxies** - Multiple proxies are listed who make decisions by consensus. If there is a disagreement, then the decision of the majority will be accepted. All individuals listed are contacted. Use additional paper, if required.
   - **Successive proxies** - Multiple proxies are listed, where the decisions of the first listed proxy will be accepted until he/she is not willing, not available or lacks capacity. That person’s name shall be removed from the list and the next proxy will be contacted. Use additional paper, if required.

2. If you do not select a Proxy, then one nearest relative substitute decision maker will be identified when you lose capacity to make your health care decisions.

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3. **The Health Care Directives and Substitute Health Care Decision Makers Act, 1997, s. 15(1)**
### Proxy(s) contact information:

Individuals listed below are (initial one): ___ Joint Proxies or ___ Successive Proxies

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
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### Instructions for proxy(s) or Substitute Decision Maker, where resident lacks capacity:

1. Name, signature and date of the proxy or substitute decision maker who completed this plan. This plan is designated as an Advance Instruction.
2. Substitute decision maker signs only when there is no appointed proxy.

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Signature of proxy</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td>Name</td>
<td>Signature of Substitute Decision Maker</td>
<td>Date</td>
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### Instructions for substitute decision maker:

1. If the substitute decision maker signed above, then provide the Substitute Decision Maker’s contact information below.

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<thead>
<tr>
<th></th>
<th>Name &amp; Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
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</table>

### Other nearest relatives contact information:

<table>
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<th>Name &amp; Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Alternate Phone</th>
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### Instructions for Physician/Designate or two treatment providers:

1. Name, signature & date of the Physician or Designate indicates they assisted in the completion of this plan. Indicate below who completed this plan.
2. Two treatment providers are to complete this plan when they initial page two. Name, signature and date of two treatment providers indicates resident lacks capacity AND does not have a proxy or substitute decision maker (i.e. no nearest relative). Indicate below who completed this plan. This plan is designated as an advance instruction.

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Signature of Physician or Treatment Provider &amp; Title</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Name</td>
<td>Signature of Designate or Treatment Provider &amp; Title</td>
<td>Date</td>
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</table>

### SI-SC Plan Review: (Staff should refer to the policy for direction on SI-SC Plan review).

1. Name, signature & date below indicates annual review without changes to this plan.
2. Two treatment providers must do annual review, if they had completed it before.

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Signature of Designate or Treatment Provider &amp; Title</th>
<th>Date of Review</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Name</td>
<td>Signature of Designate or Treatment Provider &amp; Title</td>
<td>Date of Review</td>
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</table>
SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

PHYSICIAN’S/PRACTITIONER’S ORDERS
RESUSCITATION CARE PLAN

Instructions: Reference the Resuscitation Policy for details or any clarifications.

1. This plan is to be completed by the MRP or Designate in acute care, as physician/practitioner’s orders.
2. Check off appropriate boxes and document in physician/nurses progress notes all discussions pertaining to informed consent and or informed refusal. If completing a new plan, clearly write VOID on the old plan.
3. Two treatment providers may complete this plan in an emergency or non-emergency situation when the patient lacks capacity AND there is no proxy or substitute decision maker (i.e. no nearest relative).

1. CALL A CODE: Initiate BLS immediately in the event of a cardiopulmonary arrest and provide all clinically indicated interventions including transfer to higher/alternate level of care as required.

2. DO NOT CALL A CODE: Call for urgent medical response outside of a cardiac arrest.

   In the event of a cardiac arrest, the patient or proxy(s)/substitute decision maker specifically refuses cardiopulmonary resuscitation attempts. Outside of cardiac arrest, the patient or proxy(s)/substitute decision maker will accept other clinically indicated medical interventions.

   Select options ACCEPTED by the patient or proxy(s)/substitute decision maker below:
   - Remain on ward/observation unit: Patient or proxy(s)/substitute decision maker accepts therapy available in the ward/observation unit such as cardioversion, CPAP/BiPAP, drugs, etc. Patient or proxy(s)/substitute decision maker does not want transfer to critical care.
   - Transfer to critical care (ICU/CCU/NICU/PICU): The following options are only available in critical care. The patient or proxy(s)/substitute decision maker will ACCEPT the following clinically indicated interventions while in critical care:
     - Intubation/Mechanical ventilation
     - Transcutaneous pacing
     - Vasopressors/Inotropes
   - List other treatment options not listed above that are clinically indicated and ACCEPTED:

   - List treatment options, therapies or investigations specifically DECLINED:

3. DO NOT CALL A CODE: Support natural death in the event of a cardiopulmonary arrest.

   Where appropriate, consult palliative care when this option is selected.

   Name | MRP Signature or Treatment Provider | Date | Time

   Name | Designate Signature or Treatment Provider | Date | Time

The above documented code status must be reconfirmed with patient or proxy(s)/substitute decision maker:
   - Yes reconfirmed. If not reconfirmed, the MRP/Designate must do so immediately.
INSTRUCTIONS: (Complete this section ONLY when the resuscitation decision is contested)

1. To be completed by MRP in acute care or Special-care Home(s).
2. Refer to the Resuscitation Policy for details or any clarifications.
3. Follow the steps sequentially & check completed boxes. Document in physician progress notes all discussions pertaining to consent/informed refusal & second opinions you obtained.

1.  Initiate BLS immediately upon calling a code and perform all medical interventions requested, even though MRP has determined that attempting resuscitation is not clinically indicated.
   A.  Discuss withholding resuscitation with the health care team and develop consensus before moving forward.
   B.  Discuss with the patient/resident or proxy(s)/substitute decision maker the rationale for withholding resuscitation treatment and attempt to reach consensus. Document this rationale in physician’s progress notes.
   C.  MRP to offer and assist the patient/resident or proxy(s)/substitute decision maker in seeking a second opinion.
   D.  MRP shall obtain a second opinion from a qualified physician who does not have a conflict of interest. If the second physician disagrees on the code status, then the MRP must transfer the patient responsibilities to the second physician who does not have an objection to honoring the patient’s request. If both the physicians agree on the code status, then the second physician signs below documenting their agreement.

2.  If the MRP is unable to transfer the care to another physician and a demand or request for treatment remains, the MRP and all health care team members must continue to offer resuscitation and:
   A.  Involve ethics consultation service
   B.  Involve SHR’s legal counsel.
   C.  MRP obtains approval from physician head of department (or the Senior Medical Officer, where the department head is the MRP) in writing agreeing with the MRP’s decision.

3.  The MRP provides at least 96 hours (four days) advance written notice in person to the patient or proxy(s)/substitute decision maker with the assistance of SHR Legal Counsel.
   A.  The notice must be signed by both the MRP and their physician head of department.
   B.  The physician head of department advises the responsible administrative VP.

4.  Inform the patient/resident or proxy(s)/substitute decision maker in writing and in person of their option to approach the courts to obtain an injunction. This may include a joint application.
   A.  During the 96 hours the MRP and all health care team members must continue to offer resuscitation.

5.  After 96 hours do not call a code or follow court order.
6.  Recomplete Resuscitation Care Plan or the SI-SC Plan with patient/resident or proxy(s)/substitute decision maker to reflect current code status.
Honoring Your Choices

Saskatoon Health Region believes in the importance of honoring your choices. An Advance Care Directive or a resuscitation plan can guide resuscitation decisions for individuals at hospitals or long term care. If your heart or breathing stops we want to be able to provide the care that you need and want. This brochure will help answer some common questions and help you talk to your family and health care team. The goal is to help you understand the facts about resuscitation so you can make the decision that is right for you.

Based on your health, your health care team may discuss your resuscitation plan within 24 hours of each hospital admission. At long term care, your health care team will discuss your resuscitation plan within the first eight weeks of arrival.

What if I still have questions?
We want you to discuss your questions or concerns with your health care team and feel confident with your choice. Do not hesitate to contact your health care team. Your health care team wants to help you make the decision that is right for you. You may also want to speak with Spiritual Care and First Nations and Métis Health Services through the Royal University Hospital switchboard (306-655-1000).

You can change your mind about your decision at any time. Please talk to a member of your health care team.

More Information
If you would like more information on Advance Care Directives Policy or the Resuscitation Policy, please let your health care team know. Saskatoon policies are available at https://www.saskatoonhealthregion.ca/about/Pages/Policies-RW.aspx

Reference

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Joint Ethics Committee
What causes the heart or breathing to stop?
There are many reasons why the heart or breathing can stop. Serious illness or accidental injury can damage the heart and lungs. In some cases, the heart stops as part of the natural dying process.

What happens when the heart or breathing stop?
When someone's heart stops beating, they become unable to respond within a few seconds because there is not enough blood going to their brain. During this time, they are not aware of things around them and likely do not experience pain. If the heart stops and isn't restarted again within a couple of minutes, the person will die. A decision must be made on whether or not to perform Cardiopulmonary Resuscitation (CPR).

What is Cardiopulmonary Resuscitation?
CPR restores blood flow temporarily when an individual's heart or breathing stops. CPR involves repeatedly pushing down hard and fast on the chest and may include mouth-to-mouth breaths or using a device to push air into the lungs. Electric shocks may also be used to try to correct the rhythm of the heart. CPR by itself is unlikely to “restart” the heart. CPR’s main purpose is to provide oxygen to the brain & the heart, in case blood circulation can be restored. People who have had CPR usually need advanced life support machines and medicines in a hospital intensive care setting. CPR does not improve the illness that caused the heart or breathing to stop, at best people are as healthy as they were before their heart stopped. Most people do not return to the life they previously enjoyed.

When is CPR used?
CPR is used only when your heart or breathing stops. CPR is not provided against your wishes. There are times when CPR may not be right for you. Discuss with your health care team whether CPR is right for you, given your health condition and goals. If you and your healthcare team need help discussing your CPR decision, contact Ethics Services at the Royal University Hospital switchboard (306-655-1000) for support during regular working hours and ask them to connect you with the ethics consultant on call. For more information see “Bioethics and You: Where practice meets principle” Ethics brochure.

How well does CPR work and what are the side effects?
CPR does not always work to restart the heart. CPR can sometimes cause problems like broken ribs and damage to the lungs. If blood flow during CPR is not enough for the brain, you may have trouble thinking afterwards. We suggest that you watch the video “A Decision Aid to Prepare Patients And Their Families For Shared Decision-Making About Cardio-Pulmonary Resuscitation (CPR)” available at https://vimeo.com/48147363 with a member of your health care team. Ask your doctor about how well CPR might work for you.

How do I decide about CPR?
You have the right to make decisions regarding your care and get information and support to help you make a decision. This includes choosing whether or not to receive treatments like CPR. Important things to consider are:
- All treatment options, including no treatment
- What matters most to you
- The benefits, harms and information about how well a treatment might work for you
- Your plans for future health care

When you are not able to make health care decisions, The Health Care Directives and Substitute Health Care Decision Makers Act requires your proxy(s) or substitute decision maker to make all your health care decisions based on your known wishes or (best interests when wishes are unknown). Share your wishes with your family and involve anyone who might make health care decisions for you when you are very ill.

Your Decision

An Advance Care Directive is a legal document that helps your proxy or substitute decision maker and health care team understand your choices for resuscitation and other health care treatments. If you have an Advance Care Directive, please give it to your health care team and a copy will be placed in your chart. At home, consider placing your Advance Care Directive on or in the refrigerator so that paramedics can find it and bring it to the hospital. You are encouraged to complete an Advance Care Directive with your health care team, if you do not have one.

What if I decide I don’t want CPR?
If you do not want CPR, tell your health care team. You will still need to make decisions about other medical care, for example about other medicines and tests. You can expect to receive respectful and dignified care with the support of the entire health care team to meet your physical, emotional and spiritual care needs.

CPR should not be performed on people who do not want CPR. However, it is possible that you might receive CPR against your wishes, when:
- You do not tell your health care team your wishes.
- You are not on your home unit/ward (in a hospital) or neighborhood (in long term care) when your heart or breathing stops and your resuscitation plan is not available. Example: Your heart or breathing stopped in the cafeteria.

If you believe someone received CPR against their wishes, please call the Safety Alert System at 306-655-1600 to report the incident. For more information see Safety Alert System brochure.

What if I change my mind?
You can change your mind about your decision at any time. Please talk to a member of your health care team and involve anyone who might make health care decisions for you when you are very ill.