STANDARD

New Zealand law requires that a patient be resuscitated where the procedure would be beneficial to him or her. Section 151 of the Crimes Act 1961 places a legal duty on health professionals to provide the necessities of life to patients. Further, necessary / reasonable treatment may not be withheld or withdrawn from a competent patient against their will.

OBJECTIVE

This protocol defines standards regarding Cardio-Pulmonary Resuscitation (CPR) and the decision making process on whether to provide CPR or not to particular patients.

- Section A sets out the standards for CPR.
- Section B sets out the standards required if either the patient or clinician(s) do not consider CPR to be in the patient's best interest.

STANDARDS TO BE MET

SECTION A: patients / casualties FOR resuscitation

1. In the absence of any other documentation completed in advance, the clinical staff should act in what appears clinically appropriate for the patient.

2. All staff must know how to initiate the emergency call to the appropriate response team(s) listed below: Dial 777 and state your name, the type of emergency and the location:
   2.1 Adult Cardiac Arrest / Medical Emergency Call
   2.2 Adult Trauma Call
   2.3 Paediatric Cardiac Arrest / Medical Emergency
   2.4 Paediatric Trauma
   2.5 Obstetric Emergency

3. Some areas have Medical Emergency 777 PULL or PUSH buttons which activates the MET group immediately. This button may be pulled (or pushed) in place of the 777 phone call. If the button is linked to the 777 Medical emergency pagers it will clearly state '777' on, or near the button.

4. The Emergency Department (ED) also has a protocol regarding multiple medical emergency presentations, or multiple trauma presentations (refer ED.A11.1). These are defined as CODES.
   a) Code 1 for one (1) seriously ill person
   b) Code 2 for two (2) seriously ill people
   c) Code 3 for three (3)
   d) Code 4 for 4-5 people
   e) Code 5 for 6-8 people
   f) Code 6 for 9+ casualties

5. Each code has an escalating number of staff to attend, as held by Telephony.

6. Each staff member involved in an emergency event is required to carry out their role as per protocol according to their training level.

7. Each staff member who carries a cardiac arrest pager is responsible for:
   7.1 Ensuring their resuscitation skill certificate is current to the appropriate level for their post
   7.2 Knowing how to access each of the clinical services they are covering.

| Issue Date: | Oct 2014          | Page 1 of 9                | NOTE: The electronic version of this document is the most current. |
| Review Date: | Oct 2016          | Version No: 5             | Any printed copy cannot be assumed to be the current version. |
| Protocol Steward: | Resuscitation Co-ordinator | Authorised by: Medical Director |
7.3 Ensuring the pager is retained on their person at all times during their shift, turned on with a good battery and not changed to vibrating / silent mode.

7.4 Ensuring that pager batteries are checked every day, and changed fortnightly or when low cell sound is heard.

7.5 Ensure that red emergency pagers / on call cellphones are handed over at shift changes, in person.

8. The most senior doctor who has responded to the cardiac arrest call is responsible for:
   8.1 Delegating a team leader.
   8.2 Documentation in the patient’s health record.
   8.3 Notifying the responsible clinician.
   8.4 Completing a new Clinical Staff Event in the 777 Clinical Emergency Calls Register and Resuscitation Flowchart (located on emergency trolley). This may be delegated to the Nurse Shift Leader of the area.

9. All Locum Doctors who will carry the ‘Red-Pager’ are responsible of ensuring that their advanced resuscitation skills (NZRC level 7 or equivalent) are up to date – within the last 3 years, and that they are aware of the New Zealand Resuscitation Council standards. They must familiarise themselves with the hospital layout, equipment (especially defibrillators), and emergency suction on arrival.

10. The healthcare team during resuscitation will make a collaborative decision regarding family / whanau presence. Staff are required to utilise professional judgement to give the necessary and appropriate support to significant other(s) and health team members.

11. There must be at least one (1) resuscitation trolley in each clinical area, a resuscitation pack in each service without a trolley, and staff must be aware of its location.

12. Each resuscitation trolley or pack must carry the contents approved in writing by the Resuscitation Committee.

13. Resuscitation trolleys and packs must be maintained according to protocol.

14. Every health practitioner required to be involved in resuscitation or form part of the resuscitation team must have undertaken appropriate CPR training according to BOPDHB policy 6.3.7 protocol 5 Life Support Training.

15. Any staff concerns arising from a resuscitation event will be addressed by appropriate incident debriefing and / or provision of confidential and professional counselling.

<table>
<thead>
<tr>
<th>Registers</th>
<th>777 Clinical Emergency Calls Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>APU Shift Reports</td>
<td>Approved Contractors Register</td>
</tr>
<tr>
<td>Contracts Register</td>
<td>Duty Managers Shift Reports Tga</td>
</tr>
<tr>
<td>Duty Managers Shift Reports Whk</td>
<td>ED Shift Reports Tga</td>
</tr>
<tr>
<td>ED Shift Reports Whk</td>
<td>Fridge Audit Register</td>
</tr>
<tr>
<td>GDA Register</td>
<td>Gifts Register</td>
</tr>
<tr>
<td>Non Clinical Calls Register</td>
<td>Project Register</td>
</tr>
<tr>
<td>Project Register</td>
<td>Telephony Shift Reports</td>
</tr>
<tr>
<td>Theatre Cancellations Register</td>
<td></td>
</tr>
</tbody>
</table>

Click here to log a fault with the IT Servicedesk or Phone 8453

a) Tauranga - send to the Resuscitation Co-ordinator
b) Whakatane - send to Resuscitation Co-ordinator

NOTE: The electronic version of this document is the most current. Any printed copy cannot be assumed to be the current version.
16. Reporting of 777 calls
   a) Ward Nursing Co-ordinators
      i. PACentral / Registers

      Reporter is to choose from the selection boxes - select Tauranga / Whakatane
      "Nurses / Doctors report"

      Fill in below as necessary

      Your Name *
      Full Name of person reporting the call

      Call Type *

      Date and Time of Call  11/09/2014  15:00

      777 Location (T) *

      Specific Area (T) *
      Describe where 777 took place within area identified above.

      Site (T) *
      TGA

      CPR *
      ✔

      Defibr *
      ✔

      Patient NHL *

      Patient  First Name

      Patient Surname *

      Age *

      M/F *
      ✔

      Brief Event Details *
      (Do not use patients name etc)

      Save  Cancel
All details are recorded on the above screen, then saved.

b) Telephony also record system details to ensure 777 calls are audited and reviewed as necessary.

c) **Resuscitation Co-ordinators**
   i. A summary of 777 responses is provided to the Resuscitation Committee at their scheduled meetings.
   ii. Clinical emergency 777 calls will be reviewed weekly by the Resuscitation Co-ordinator and audited.

**SECTION B: Patients / casualties DO NOT ATTEMPT RESUSCITATION (DNAR) / ALLOW NATURAL DEATH (AND)**

1. **In the absence of any other documentation completed in advance, clinical staff should act in what appears clinically appropriate for the patient.**

2. End-of-life and resuscitation decisions can be made early in the patient’s care, such as following discussion in the ED / Admission Planning Unit (APU) and may be patient or health practitioner initiated.

3. Health practitioners should follow a robust decision-making process in making the decision regarding a DNAR / AND, as per protocol 1.

4. A competent patient may at any time make a free and informed request not to be resuscitated, in accordance with protocol and BOPDHB policy 1.1.1 Informed Consent.

5. All decisions / advance directives should be appropriately documented by use of the designated forms and documented in the health record.
6. Characteristics Of Patients For Whom 'DNAR / AND' Decision May Be Appropriate.
   a) Any patient who after end-of-life discussions wishes 'natural death' in the event of a cardiac arrest.
   b) Patients with a very poor prognosis for whom resuscitation would be clinically futile (see Definitions) should be considered 'DNAR / AND'.
   c) Consideration of the poor prognosis needs to include:
      i. quality and length of life which needs to be assessed as accurately as possible,
      ii. likely disease / illness progression,
      iii. assessment of the attitudes of all involved in the decision-making, to ensure that paternalism is not over-riding the patient’s right to have autonomy, dignity and respect.

7. Making The 'DNAR / AND' Decision
   b) Protocol 2 provides guidelines for discussing DNAR / AND authorisation with patients and others.
   c) It is crucial to involve a competent patient in the decision making process. Informed consent, if required, should be obtained in accordance with the requirements of BOPDHB policy 1.1.1 Informed Consent.
   d) Where the patient is not competent, key persons e.g. the family / whanau or Enduring Power of Attorney may be consulted to assist in determining the patient’s wishes, and their names and relationship to the patient identified and documented in the patient's health record. The requirements of policy 1.1.1 Informed Consent provide further guidance in this circumstance. It is Important that Staff understand the difference between normal Power of Attorney, and Enduring Power of Attorney - with Personal Care and Welfare power.
   e) No person (unless authorised under an Enduring Power of Attorney) is legally entitled to consent or refuse consent to medical treatment on the behalf of an adult who lacks decision-making capacity. They should be consulted and their views taken into account, but they cannot insist on treatment or non-treatment. However, if such a party continues to disagree with a Consultant's recommendation to make a 'DNAR / AND', the Consultant should seek legal advice from the BOPDHB Legal Advisor. If there is any doubt or a decision has not yet been made, routine cardiopulmonary resuscitation should be performed without delay
   f) The patient may have made an advance directive. The issues surrounding an advance directive are similar to those relating to any patient's consent to a procedure / treatment. These are:
      i. Whether the patient was competent to make the particular decision, when the decision was made; and
      ii. Whether the patient made the decision free from undue influence; and
      iii. Whether the patient was sufficiently informed to make the decision; and
      iv. Whether the patient intended his / her directive or choice to apply to the present circumstances.
   g) Advanced directives are not necessarily binding.
   h) Any staff discussion that intends to revoke an DNAR / AND authorisation should involve:
      i. The patient’s consultant or delegated registrar
      ii. A suitably experienced nurse e.g. ward co-ordinator
      iii. Other staff as appropriate.
8. Patient or Health Practitioner Initiated DNAR / AND
   a) The New Zealand Bill of Rights 1990 Section 11 states: Everyone has the right to refuse any medical treatment. There is no legal requirement that life saving treatment must be given if a competent (refer to Glossary of Terms / Definitions) patient does not want it.
   b) All patients requesting DNAR / AND status should be given a copy of the BOPDHB Resuscitation Patient Information Sheet and an appropriate member of staff should be available to discuss the contents with them (see Protocols 1 and 2).
   c) If a competent patient makes a free and informed request not to be resuscitated the request should be documented on the Patient Initiated DNAR / AND Authorisation Form (7447) and in the patient's health record (this is the equivalent of Informed Consent).
   d) Signature of the DNAR / AND form by the consultant or delegate indicates that this information has been given and has been understood by the patient.
   e) Such a request should be current (see BOPDHB Glossary of Terms / Definitions and section 5 below) as determined by the clinical team. The consultant has ultimate responsibility for this.
   f) If there is incongruity between the patient's request not to be resuscitated, and the patient's likely clinical outcome, then the patient must be assessed and advised by the registrar on duty or the consultant responsible. Psychiatric assessment may be requested if needed, and legal advice sought from BOPDHB Legal Advisor.

9. Medically Initiated DNAR / AND
   a) When a patient approaches the end of any terminal process, or their perception of end of natural life, and death is anticipated, the staff responsible for the patient's care should review the appropriateness of the treatment plan, including decisions about resuscitation.
   b) No health professional is required to provide clinical treatment that is not clinically indicated. CPR does not differ from other clinical treatments / procedures in that it should be used only where it can be of benefit to the patient.
   c) Any patient receiving palliative care, rather that active treatment, should have resuscitation attempt discussed with them. Hospice patients generally sign a DNAR / AND form at their admitting centre (e.g. Waipuna Hospice). However, Oncology / Cancer Centre patients are for resuscitation unless a DNAR / AND form has been signed.
   d) There are circumstances in which the decision 'DNAR / AND' form should be made in consultation with the patient's key person(s). These circumstances include:
      i. where it is acknowledged that a terminally ill patient has indicated that they do not wish to be fully informed about their condition or to be involved in decision-making. The wishes of such patients should be respected and clearly documented in the patient's health record. It is recommended that this be countersigned by another clinical staff member.
      ii. where the patient cannot make the decision and seeks to have the decision made for them.
      iii. where the patient is incompetent e.g. because of a decreased level of consciousness, some forms of aphasia, patient is a baby or child, etc.
   e) In all such cases, the consultant or delegated registrar must:
      i. clearly identify the status of key persons and as far as possible verify that they are in fact the patient's approved spokesperson(s).
      ii. for Māori, clearly identify the whānau spokesperson for the patient. Maori Health Service (Te Pou Kokiri Whakatane, Kaupapa Social Workers Tauranga) can be used to assist in communication with whānau.
iii. discuss the patient’s situation in detail with the patient’s key person(s) if they are available (reasonable attempts must be made to locate them). A copy of the BOPDHB Resuscitation Patient Information Sheet can be provided to the key person(s) if it is felt it can help decision-making.
iv. ensure the patient’s cultural requirements are met as far as possible
f) Where there is conflict between key persons, they should be encouraged to meet and agree. If no agreement is reached, the consultant or delegated registrar will decide in consultation with the clinical team. The consultant should access legal advice if needed from BOPDHB Legal Advisor.
g) Where the patient is an incompetent child, and where the parent or guardian requests DNAR / AND status for the patient, a Do Not Attempt Resuscitation – Allow Natural Death Form (7447) may be signed.
h) Where the patient is a competent child, and where the parent or guardian requests DNAR / AND status for the patient, the consultant / delegated registrar should seek advice from the BOPDHB Legal Advisor.
i) Where a patient is an incompetent adult without a welfare guardian appointed, or for any patient where resuscitation is not clinically indicated, a Do Not Attempt Resuscitation – Allow Natural Death Form (7447) must be completed by the consultant or delegated registrar. This ensures clarity of communication with other members of the clinical team, and also records information provided to key persons. This is necessary to ensure all staff are clear whether resuscitation is to be attempted or not.
j) The topics listed on the Do Not Attempt Resuscitation – Allow Natural Death Form should be discussed with the patient and / or key persons, as appropriate. Further guidance on topics that should be discussed with key persons may be found in Protocol 2 Guidelines For Discussing DNAR / AND Authorisations.
k) The consultant or delegated registrar may feel that discussion with the patient / key person(s) regarding DNAR / AND is inappropriate given an individual patient’s circumstances. However, it is essential that the patient and / or key person(s) must be aware that death due to the illness / disease is certain and cannot be prevented, and that any resuscitation effort would not have a good outcome. Allowing natural death gives family time to prepare for the conclusion of life. This allows for key person(s) to ask questions and clarify the situation.
l) Signature on the Do Not Attempt Resuscitation - Allow Natural Death Form (Protocol 4) by medical staff indicates the information has been given or attempted to be given and the staff believe it was understood by the patient or family / whanau. In authorising a medically initiated DNAR / AND authorisation, the Consultant or Registrar accepts responsibility for the non-performance of resuscitation attempt.
m) Where there is conflict between the consultant and the patient / guardian regarding an DNAR / AND decision, advice from the BOPDHB Legal Advisor should be sought.

10. Documentation Of The Patient’s DNAR / AND Status
a) In all cases the decision not to attempt resuscitation must be fully documented in the patient’s health record on the appropriate DNAR / AND form.
b) The patient’s DNAR / AND status may only be documented by the consultant or delegated registrar.
c) The reasons underlying the medically initiated DNAR / AND form should be clearly documented on the form itself and additional notes can also be made in the patient’s health record.
d) If a patient arrives at the hospital from a REST HOME with a DNAR / AND form signed by themselves, family / whanau member or Power of Attorney, on an appropriate form, this should be adhered to. No further discussion is necessary,
except if clarification is required. However, as staff will be searching through the patient’s health record for a BOPDHB DNAR / AND form, it is preferable to have this filled out to avoid error at the outset of the cardiac arrest.

e) The appropriate rest home should be contacted and a faxed copy obtained if no DNAR / AND form is brought with the patient.

11. Revoking A Not For Resuscitation Authorisation
   a) If the patient wishes to revoke a Patient Initiated DNAR / AND Authorisation, or the Consultant or delegated Registrar decides that a Medically Initiated DNAR / AND Authorisation is no longer appropriate, then the DNAR / AND authorisation form must be ruled through diagonally in ink and endorsed CANCELLED, and this action highlighted in the patient’s health record, and nursing staff informed. The endorsement must be dated and signed by the:
      i. Consultant or Registrar, with the full name and designation of the Consultant or Registrar stated; and
      ii. patient - in the case of the Patient Initiated DNAR / AND Authorisation.

12. Reviewing a DNAR / AND Authorisation
   a) The consultant will ensure regular monitoring of changes in the patient's health status that are relevant to determining the appropriateness of continuing the DNAR / AND status of the patient and if necessary call a meeting of the team and key persons.
   b) The NFR decision must be re-evaluated and re-documented:
      i. on each admission; or
      ii. whenever the patient’s health status alters.

13. Treatment Of Patients Who Are DNAR / AND
   a) Patients who are DNAR/AND, must still receive such treatment as deemed appropriate by the consultant and in consultation with members of the clinical team.
   b) A DNAR / AND order should not affect other medical or nursing care.

14. Success Indicators
   a) A Post-Resuscitation Audit Form is completed for each resuscitation event and sent to the Resuscitation Committee. This form does not need to be completed if resuscitation is not attempted.
   b) All DNAR / AND Authorisations:
      i. Medical Alert is completed
      ii. on each admission alert status is checked and documented in patient’s health record that still current
      iii. if not current, removal of Medical Alert is to be actioned.

REFERENCES

- Children Young Persons and Their Families Act 1989
- Crimes Act 1961
- Code of Health and Disability Service Consumers’ Rights 1996
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- New Zealand Bill of Rights 1990
- Protection of Personal and Property Rights Act 1988
ASSOCIATED DOCUMENTS
- Bay of Plenty District Health Board policy 6.3.7 Cardiopulmonary Resuscitation (CPR)
- Bay of Plenty District Health Board policy 6.3.7 protocol 1 - CPR - Decision Making Process
- Bay of Plenty District Health Board policy 6.3.7 protocol 2 – CPR - Discussing 'NFR' Authorisation With Patients And Key Persons
- Bay of Plenty District Health Board policy 6.3.7 protocol 3 – CPR - Maintenance of Resuscitation Equipment
- Bay of Plenty District Health Board policy 6.3.7 protocol 4 – CPR – Life Support Training
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.C2.1 Cardiopulmonary Resuscitation (CPR)
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.C2.2 CPR - Use of Automated External Defibrillation (AED)
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 6.1.4 Advanced Directives
- Bay of Plenty District Health Board policy 6.1.5 protocol 1 Alerts – Medical – Allergic Responses, Adverse Reaction and High Risk Issues
- Bay of Plenty District Health Board policy 7.103.1 protocol 17 Certification - Life Support
- Bay of Plenty District Health Board Hospital Support Services protocol HSS.T1.1 777 Response Procedure (Durapage)
- Bay of Plenty District Health Board What is Resuscitation, and what are my options. Patient Information Brochure – viewable only. Order from Design & Print Centre
- Bay of Plenty District Health Board Do Not Attempt Resuscitation – Allow Natural Death form (7447) – viewable only. Order from Design & Print Centre
- Bay of Plenty District Health Board 777 phone list - Emergency Response list per groups (TGA & WHK)
- Bay of Plenty District Health Board Form FM.A11.1 Alert - Medical
- Bay of Plenty District Health Board 777 Clinical Emergency Calls Register