



**Evidence Informed
 Guideline**

Guideline Name:

**Advance Care Planning
 (Operating Room and
 Immediate Postoperative
 Period)**

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Approval Signature:

Date:

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Supercedes:

1. Introduction:

- Some patients/residents/clients with a Comfort Care option, Medical Care option, or Health Care Directive become candidates for surgical procedures intended to provide them with significant benefit even though the procedure may not change the natural history of the underlying disease. When such patients undergo surgical procedures and the accompanying sedation or anesthesia, they are subjected to new and potentially correctable risks of cardiopulmonary arrest. Many of the therapeutic actions employed in resuscitation (for example, intubation, mechanical ventilation, and administration of vasoactive drugs) are also an integral part of anesthetic management, and it is appropriate that the patient be so informed. The Goals of Care of such patients during the operative procedure and during the immediate postoperative period may need to be modified prior to surgery.
- Policies that lead either to the automatic enforcement of Resuscitation or to disregarding or automatic cancellation of Comfort Care or Medical Care option, during the surgery and recovery period may not sufficiently address a patient's right to self-determination. An institutional policy of automatic cancellation of Comfort Care or Medical Care options in cases where a surgical procedure is to be carried out removes the patient from appropriate participation in decision making. Automatic enforcement without discussion and clarification may lead to inappropriate perioperative and anesthetic management.

2. Definitions:

2.1. Advance Care Planning

The overall process of dialogue, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential life threatening illness treatment options and Goals of Care are being considered or revisited.

2.2. Goals of Care

The intended purposes of health care interventions and support is recognized by both a Patient or substitute decision-maker and the Health Care Team. Goals of Care include:

- Comfort Care (C) – Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life **excluding** attempted resuscitation.
- Medical Care (M) – Goals of Care and interventions are for care and control of the Patient's condition. The Consensus is that the patient may benefit from, and is

accepting of, any appropriate investigations/interventions that can be offered **excluding** attempted resuscitation.

- Resuscitation (R) – Goals of Care and interventions are for care and control of the Patient's condition. The Consensus is that the patient may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered **including** attempted resuscitation.

NOTE: In the Operating Room and in the immediate postoperative period, resuscitation (without clarification from the patient or Substitute Decision-Maker) means "do everything"

2.3. **Health Care Directive (HCD)**

A self-initiated form used in Advance Care Planning that complies with the provisions of the Health Care Directives Act. It allows individuals to make health care preferences known in the event that they are unable to express them. In Manitoba, a Health Care Directive may indicate the type and degree of health care interventions the person prefers and/or may indicate the name(s) of a person(s) who has been delegated to make decisions (i.e. a 'Proxy'). Refer to <http://www.gov.mb.ca/health/livingwill.html>

2.4. **Substitute Decision-Maker**

A third party identified to participate in decision-making on behalf of a person who lacks decision making capacity, concerning a proposed procedure(s), treatment(s), or investigation(s). The task of the Substitute Decision-Maker is to faithfully represent the known preferences or, if the preferences are not known, the best interests of the incapable patient. See WRHA Advance Care Planning Policy #110.000.200 for further clarification.

3. **Purpose of Advance Care Planning for the surgical patient:**

- 3.1. Discussion of options with the patient/substitute decision-maker.
- 3.2. To record the collaborative clinical management decisions between the patient/substitute decision-maker and the health care team.
- 3.3. Communication of consensus of understanding between all health care team members.

4. **Standards of care/statements/guidelines of professional associations related to Resuscitation and Advance Care Plans for patients undergoing surgery:**

4.1. **Canadian Anesthesiologists' Society Guideline "Peri-operative status of *Do Not Resuscitate* and Other Directives Regarding Treatment":**

"Any DNR order (Comfort Care or Medical Care as per WRHA Policy) and/or other directive must be reviewed before patients undergo anesthesia. The goal of the review:

- is a shared decision that respects the wishes, interests, and values of the patient and the clinical judgment, expertise, and ethical obligations of the of the care provider(s); and
- ensure a transparent decision-making process that will promote communication and trust between the patient and the care providers.

4.2. **American Society of Anesthesiologists Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders:**

Policies automatically suspending DNR orders (Comfort Care or Medical Care as per WRHA Policy) or other directives that limit treatment prior to procedures involving

anesthetic care may not sufficiently address a patient's rights to self-determination in a responsible and ethical manner.

4.3. College of Physicians and Surgeons of Manitoba #1602 “Withholding and Withdrawing Life Sustaining Treatment”:

A patient has the right to consent to and/or refuse medical treatment, including life-sustaining treatment, where it is possible for the patient to give or refuse consent. The consent or refusal must be voluntary and informed in that the nature of treatment and its benefits and risks and alternatives to treatment are understood.

4.4. Canadian Medical Association (CMA) “Advance Directives for Resuscitation and Other Life-Saving or Sustaining Measures”:

The CMA holds that the right to accept or reject any treatment or procedure ultimately resides with the patient or appropriate proxy. This includes the right to accept or refuse resuscitative as well as other life-saving or sustaining measures should they become medically indicated.

4.5. American College of Surgeons Statement on Advance Directives by Patients: “Do Not Resuscitate” in the Operating Room:

The patient and the physicians who will be responsible for the patient's care should discuss the new risks and the approach to potential life-threatening problems during the perioperative period. The results of such discussions should be documented in the record.

4.6. “Joint Statement on Resuscitative Interventions” approved by the Canadian Healthcare Association, CMA, Canadian Nurses Association, and the Catholic Health Association of Canada and was developed in cooperation with the Canadian Bar Association:

This joint statement replaces the 1984 Joint Statement on Terminal Illness and applies to all recipients, including children. Guiding principles of the statement include:

- Good health care requires open communication, discussion and sensitivity to cultural and religious differences among caregivers, potential recipients of care, their family members and significant others.
- A person must be given sufficient information about the benefits, risks and likely outcomes of all treatment options to enable him or her to make informed decisions.
- A competent person has the right to refuse, or withdraw consent to, any clinically indicated treatment, including life-saving or life-sustaining treatment.
- When a person is incompetent, treatment decisions must be based on his or her wishes, if these are known.
- When an incompetent person's wishes are not known, treatment decisions must be based on the person's best interests, taking into account:
 - The person's known values and preferences
 - Information received from those who are significant in the person's life and who could help in determining his or her best interests
 - Aspects of the person's culture and religion that would influence a treatment decision, and
 - The person's diagnosis and prognosis.
- There is no obligation to offer a person futile or nonbeneficial treatment. As a general rule a person should be involved in determining futility in his or her case.

- People likely to benefit from CPR should be given this treatment if the need arises, unless they have specifically rejected it. People for whom the benefit of CPR is uncertain or unlikely should be given this treatment if the need arises, unless they have specifically rejected it. CPR should be initiated until the person's condition has been assessed.
- Situations in which CPR should not be performed include those who have rejected CPR and those who almost certainly will not benefit from it.

5. Guidelines for decision making related to Advance Care Planning in the OR and immediate postoperative period:

NOTE: Advance Care Planning in the perioperative setting is only unique if the patient has placed limitations on care. A Goals of Care option or Health Care Directive that does not limit resuscitation (see 2.2), does not need to be re-addressed prior to surgery.

- The timing of the initiation of discussion is dependent on the clinical situation and should occur preoperatively.
- The needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care. A good therapeutic relationship is founded on mutual trust and respect between providers and recipients of care.
- The primary goal of care is to provide benefit to the person receiving care. Patients offered a surgical intervention determine whether the proposed treatment is beneficial to them.
- The competent person has the right to refuse any surgical intervention and/or other medical treatments if they do not consider them beneficial, whether with respect to physical, psychological, spiritual, social or other considerations.

5.1. Review:

- Is the patient or designated substitute decision-maker aware of the Goals of Care options and do they understand the significance of the options?
- What was the original meaning and intent of the Goals of Care option chosen or Health Care Directive unrelated to the proposed procedure? What exactly does the Comfort Care or Medical Care option or Health Care Directive mean to the patient or the patient's Substitute Decision-Maker? For example, does a Comfort Care or Medical Care option or Health Care Directive from a patient really mean "no resuscitation" under any circumstances or is it intended to have a more limited meaning, e.g. no resuscitation only if recovery is remote or there is no chance of recovery?
- When, and in what context was the Goals of Care or Health Care Directive put in place? Is the Goals of Care option or Health Care Directive still relevant? Have the patient's circumstances changed sufficiently to warrant revising it?
- Is the Goals of Care or Health Care Directive "location sensitive"? For example, some Goals of Care or level-of-intervention documents for residents living in chronic care facilities may have been put in place because of the absence of timely resuscitative response mechanisms in that facility. These Goals of Care indicating level-of-intervention may not apply following transfer to an acute health care facility, where such limitation does not exist. They should be reviewed thoroughly with patients and/or designated Substitute Decision-Makers.

5.2. Communicate:

- Communication between patient, Substitute Decision-Makers, and all members of the healthcare team is imperative.

- The goal is a clear, shared understanding of the order of directive in question and the person's wishes for end of life care.
- Communication and discussion among those involved in providing care to the person are vital in ensuring that the individual's decisions are respected.
- Discussion with the patient should include, but is not limited to:
 - Normal anesthesia practices that may be similar to performance of resuscitation (i.e. ventilation, intubation); and
 - Nature of the patient's condition, prognosis, surgery/anesthesia options and expected benefits or burdens of those options.

5.3 Clarify:

- Following clarification of the nature of an existing Goals of Care or Health Care Directive, further specific discussion with the patient or designated Substitute Decision-Maker should occur with the intention of clarifying explicitly the status of the Goals of Care or Health Care Directive with respect to proposed surgery or other invasive diagnostic or therapeutic procedures.
 - Review the specific anesthetic procedures required to carry out the proposed surgery or diagnostic procedure. Are they consistent with the meaning, intent, and shared understanding of the existing Goals of Care or Health Care Directive?
 - If a cardiac arrest or other major adverse event were to occur as a consequence of surgery or a diagnostic procedure, but full recovery after immediate resuscitation could normally be anticipated, discuss whether the Goals of Care or Health Care Directive should be modified or suspended.
 - If a cardiac arrest were to occur in the peri-operative period, but not as a consequence of the surgical or diagnostic procedure, discuss whether the Goals of Care or Health Care Directive should remain in place.
 - One of the three following modifications to the Goals of Care or Health Care Directive may provide for a satisfactory outcome in many cases.
 - Suspend the current Goals of Care or Health Care Directive: the patient or designate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.
 - Modify the current Goals of Care or Health Care Directive: The patient or designate may allow the anesthesiologist and surgical team to use clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient's stated goals and values.
 - Continue unchanged with the current Goals of Care or Health Care Directive: The patient or designate may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designate about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused.
 - Plans for postoperative care should indicate if or when the original, pre-existent Advance Care Plan Goals of Care form or Health Care Directive to

limit the use of resuscitation procedures will be reinstated. This should be determined during the preoperative discussion between the patient and the healthcare provider, for example the patient may indicate to suspend a Comfort Care option, Medical Care option, or Health Care Directive until they are out of the OR, until they are back on the patient care area, or for the duration of the acute hospital stay. Consideration should be given to whether continuing to provide the patient with a time-limited or event-limited postoperative trial of therapy would help the patient and whether continued therapy would be consistent with the patient's goals. Communication with the Intensive Care Unit (ICU) attending physician, when time permits, could allow confirmation of any aspect of ICU care directly with the patient.

- It is important to discuss and document whether there are to be any exceptions to the injunction(s) against intervention should there occur a specific recognized complication of the surgery or anesthesia.
- Concurrence on these issues by the surgeon and the anesthesiologist is required for Advance Care Planning. If possible, these physicians should meet together with the patient when these issues are discussed. This duty of the patient's physicians is deemed to be of such importance that it should not be delegated. Other members of the health care team who are (or will be) directly involved with the patient's care during the planned procedure should, if feasible, be included in this process.

5.4 Document:

- Any clarifications or modifications made to the patient's Advance Care Planning Goals of Care should be documented in the medical health record. Documentation is required that reflects the dialogue between the patient and/or substitute decision-maker and the healthcare team related to treatment goals should cardiac arrest occur in the Operating Room.

5.5 Convey:

- Once a decision is reached regarding interpretation of the patient's Advance Care Planning Goals of Care, the surgeon must continue his or her leadership role in conveying the patient's wishes to the members of the operating room team (and others as applicable), helping the operating room team members understand and interpret the patient's wishes.

5.6 Emergency situations:

- In an emergency situation, there may be insufficient time to work through the steps above. Even in an emergency situation, however, every attempt should be made to clarify a pre-existing Advance Care Planning Goals of Care with the patient or Substitute Decision-Maker.
- If a pre-existing Advance Care Planning Goals of Care cannot be discussed with a patient or Substitute Decision-Maker, care providers should make decisions that, to the greatest extent possible, protect and promote the interests of the patient.

5.7 When conflicts arise:

In circumstances of irreconcilable conflict, facility administration should be notified. The joint Statement developed cooperatively and approved by the Boards of Directors of the Canadian Healthcare Association, the Canadian Medical Association, the

Canadian Nurses association and the Catholic Health Association of Canada, “Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care” (available at www.cma.ca) offers guidance in resolving ethical conflicts about the appropriateness of initiating, continuing, withholding or withdrawing care or treatment. Other documents providing guidance include:

- WRHA policy #110.000.200 Advance Care Planning – Goals of Care also provides guidance.
- Physicians may be guided by the College of Physicians and Surgeons of Manitoba Statement #1602: Withholding and Withdrawing Life-Sustaining Treatment.

6.0 References

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- 6.3 Canadian Anesthesiologists’ Society Committee on Ethics. (2002). Peri-operative status of “do not resuscitate” (DNR) orders and other directives regarding treatment. Retrieved February 2, 2010 from the World Wide Web: http://www.cas.ca/members/sign_in/guidelines/do_not_resuscitate/ethics.pdf
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