ADVANCE CARE PLANNING IN THE PERIANESTHESIA SETTING

RAMONA HACKETT RN., BA., MScN., PANC(C)
Clinical Educator, PeriAnesthesia Services
Sunnybrook Health Sciences Centre,
Toronto, Ontario

OBJECTIVES

- Review history of CPR during surgery
- Understand the rationale for performing CPR during surgery
- Understand the rationale for NOT performing CPR during surgery
- Summarize new intraoperative “Code” orders
- Summarize Sunnybrook’s new person-centred process for determining patient’s Advance Care Plan during OR and Phase 1 recovery

CASE STUDY

- Mrs. B is a 52 year old woman with multiple myeloma and a life expectancy of 6 months.
- Admitted to the hospital with acute abdominal pain and suspected bowel obstruction.
- As an in-patient, Mrs. B made the decision No CPR
- Anesthesia consult was completed; code status not discussed
- During surgery, patient became unstable and arrested. CPR/ACLS provided and patient revived
- Post op, patient came to PACU intubated, on numerous inotropes, and no beds were available in the ICU.
- Patient's husband was updated by the surgeon and when he came to see the patient, he was very upset expressing his wife would not have wanted to be in this situation
- PACU nurses were not clear on patient's Code Status

IS IT ETHICAL FOR HEALTH CARE PROVIDERS TO DISREGARD A PATIENT'S WISHES, VALUES AND BELIEFS DURING THE INTRAOPERATIVE PERIOD?

INCIDENCE AND RISK FACTORS

2015 USA National Anesthesia Clinical Outcomes Registry:

- risk of cardiac arrest was 5.6 per 10,000 cases
- associated mortality from the arrest of 30-55.7%.
- the rate of cardiac arrest increased with age and ASA physical status (III/IV)
- As many as 15% of patients with DNR orders will undergo surgery, whether provoked by their underlying terminal disease or for unrelated reasons

CPR DURING SURGERY: HISTORICAL REVIEW

- CPR was first described in the 1960's-immediate efforts to prevent sudden, unexpected death
- By the 1970's DNR orders were automatically suspended during the OR-assuming the patient would wish to be resuscitated
- In the 1980's in a report by the President's Commission for the Study of Ethical Problems in medicine determined all patients should be "Full Code" unless otherwise explicitly documented
- In 1993, the American Society of Anesthesiologists published guidelines to promote the patient's wishes of their resuscitation status during surgery

- In 2000, in a random sample of nurse anesthetists, 50% indicated there were hospital DNR or No CPR policies in place
- Of those, 67.2% indicated the policy involved automatic suspension of these orders during surgery, 20% indicated there was required reconsideration for surgical patients, and the rest were unsure.

- ***At Sunnybrook, our policy <u>did not</u> include reconsideration and "No CPR" orders were suspended during surgery***

RATIONALE FOR PERFORMING CPR DURING SURGERY

Reasons cited include:

- a desire to save the patient
- the extensive resuscitation training HCP's possess
- the resources invested in the planned surgery
- concerns that the surgical insult or anesthetic administration may have precipitated the cardiovascular collapse
- Anesthesiologists are responsible for maintaining patients' cardiovascular and respiratory systems; and portions of ACLS are provided during normal anesthesia care
- Intraoperative cardiorespiratory arrests differ from cardiorespiratory arrests outside the perioperative environment: 32-55.7% of patients survive intraoperative arrests
- Ethical/moral opposition "Do no harm" (beneficence)

RATIONALE FOR NOT PERFORMING CPR DURING SURGERY

- Patient may agree to treatment, but be unwilling to have resuscitative efforts attempted
- A No CPR order ethically should not be suspended without the patient's informed consent
- Self-determination must be honoured
- ***Advance Care Plan***

WHAT HAS CHANGED?

- Move towards a patient-centered level of care where goals of care and expectations are clearly identified ahead of time

- Developed clear documentation entitled "Temporary Revision of Existing No CPR order during OR procedures and Phase 1 Recovery period in PACU"

Temporary Revision of Existing No CPR Order during OR Procedures and the Phase 1 Recovery period in PACU

This form is to be completed at the mandatory preoperative Anesthesia consultation for all patients with a No CPR Order who require a non-emergent operation

Patient ID

THE FOLLOWING TEMPORARY REVISIONS OF THE NO CPR ORDER IS EFFECTIVE FROM TIME OF SURGERY UNTIL THE PATIENT COMPLETES PHASE 1 OF RECOVERY IN THE PACU ON THE DAY OF THE PROCEDURE AND AFTER THAT TIME THE PREVIOUS ORDERS RETURN

(Please place one checkmark in box 1-3. If box 2 is checked, please indicate which conditions are applicable)

☐ 1. Full resuscitation measures to be employed regardless of the cause of the clinical event requiring resuscitation

☐ 2. Limited resuscitation. Resuscitation should be attempted only if, in the clinical judgment of the attending anesthesiologist and surgeon, one or more of the following conditions are met:
- ☐ the clinical events are believed to be both temporary and reversible (e.g. reversible complication)
- ☐ resuscitation efforts will support the following goals of the patient:

_____
_____

☐ 3. No resuscitation regardless of the cause of the clinical event requiring resuscitation

Date of discussion (YYYY/MM/DD):	Time: __:__ (24 Hour Clock)	
Patient capable of providing consent for medical treatment (circle appropriate answer):	YES	NO
Name of Substitute Decision Maker (SDM) if patient incapable:		
Date of No CPR order (YYYY/MM/DD):	Proposed procedure:	

I certify that I have explained to the patient or Substitute Decision Maker that the previous No CPR order will be in place when the patient completes Phase 1 of Recovery in the PACU

Print name of staff anesthesiologist completing form	Signature of anesthesiologist	Date (YYYY/MM/DD) Time:
Print name of staff surgeon verifying that he/she has reviewed the above prior to anesthesia	Signature of staff surgeon	Date (YYYY/MM/DD) Time:

YES, NO, MAYBE

1. **Full resuscitation measures to be employed regardless of the cause of the clinical event requiring resuscitation.**
2. **No resuscitation regardless of the cause of the clinical event requiring resuscitation.**
3. **Limited resuscitation. Resuscitation should be attempted only if, in the clinical judgment of the attending anesthesiologist and surgeon, one or more of the following conditions are met:**
    - the clinical events are believed to be both temporary and reversible (e.g. reversible complication)
    - resuscitation efforts will support the following goals of the patient: _____

WHAT ARE SOME ACCEPTABLE INTERVENTIONS PATIENT MAY AGREE TO?

The anesthesiologist discusses pre-operatively with the patient and/SDM:

- Witnessed “shockable” rhythms: VF/VT
- Anesthesia-induced cardio-respiratory arrest: medications, intubation
- Iatrogenic complications: bleeding

OUR NEW PROCESS: PRE-OPERATIVELY

1. Surgeon has an in- patient with a No CPR order requiring surgery. Contacts the anesthesia co-ordinator and discusses patient and situation.

2. Anesthesiologist confirms No CPR status of patient in the chart and obtains "The Temporary Revision form"

3. Conducts consultation with patient and/or SDM and reviews options for revision

4. Anesthesiologist completes the form which acts as an Order

OUR NEW PROCESS: DAY OF SURGERY

- No CPR order in effect until patient enters OR theatre
- The Anesthesiologist assigned to the OR reviews documentation and ensures the Surgeon also signs the form indicating awareness of patients/SDM's wishes PRIOR to the Surgical Safety Checklist
- During the Surgical Safety Checklist, the Time Out and Debrief stages, the code status of the patient is announced
- The Anesthesiologist will inform PACU Nurse of the document and the resuscitation status that is in place until the Phase 1 of Recovery is complete
- The PACU RN provides verbal report to the next nurse

Challenges

- Roll-out was expected to occur quickly
- Interprofessional push back
  - Nurses embraced
  - Physicians …
- There are still patients who are being missed

"Rather than perceiving that they are doing nothing, something has indeed been done; the wishes of the patient have been respected, their autonomy has been preserved and they have been allowed to die with dignity. Complying with these wishes represents one of the greatest challenges that we must face" (Ewanchuk M, Brindley PG., 2006)

Sunnybrook
HEALTH SCIENCES CENTRE
when it matters MOST

With gratitude to Blair Henry, Senior Ethicist, SHSC & NYGH for his knowledge, help and insight into helping facilitate ACP in our surgical patients

References

- Ball, K. (2009). Do-not-resuscitate orders in surgery: decreasing the confusion. *AORN Journal*, *89*(1), 140-150. doi:10.1016/j.aorn.2008.12.019
- Clark, G., Lucas, K., & Stephens, L. (1994). Ethical dilemmas and decisions concerning the do-not-resuscitate patient undergoing anesthesia. *AANA Journal*, *62*(3), 253-256.
- Donovan, D. W. (2015). Is It Ethical to Suspend A DNR Order in Surgery?. *Health Progress*, *96*(4), 63-67.
- Dunn, R., Ahn, J., & Bernstein, J. (2016). End-of-life care planning and fragility fractures of the hip: Are we missing a valuable opportunity? *Clinical Orthopaedics and Related Research®, 474*(7), 1736-1739. doi:10.1007/s11999-015-4675-1
- Ewanchuk M, Brindley PG. Ethics review: Perioperative do-not-resuscitate orders – doing “nothing” when “something” can be done. Critical Care. 2006;10(4):219. doi:10.1186/cc4929.
- Grimaldo, D., Wiener-Kronish, J., Jurson, T., Shaughnessy, T., Curtis, J., & Liu, L. (2001). A randomized, controlled trial of advance care planning discussions during preoperative evaluations. *Anesthesiology*, *95*(1), 43-50.
- Kalkman, S., Hooft, L., Meijerman, J. M., Knape, J. A., & van Delden, J. M. (2016). Survival after Perioperative Cardiopulmonary Resuscitation: Providing an Evidence Base for Ethical Management of Do-not-resuscitate Orders. *Anesthesiology*, *124*(3), 723-730. doi:10.1097/ALN.0000000000000873
- Schubart, J. R., Green, M. J., Van Scoy, L. J., Lehman, E., Farace, E., Gusani, N. J., & Levi, B. H. (2015). Advanced Cancer and End-of-Life Preferences: Curative Intent Surgery Versus Noncurative Intent Treatment. Journal Of Palliative Medicine, 18(12), 1015-1018. doi:10.1089/jpm.2015.0021
- Steffens, N. M., Tucholka, J. L., Nabozny, M. J., Schmick, A. E., Brasel, K. J., & Schwarze, M. L. (2016). Engaging Patients, Health Care Professionals, and Community Members to Improve Preoperative Decision Making for Older Adults Facing High-Risk Surgery. *JAMA Surgery*, *151*(10), 938-945. doi:10.1001/jamasurg.2016.1308
- Wachter, K. (2012). More DNR patients die after emergency surgery. *Caring For The Ages*, *13*(8), 12.
- Schofield, P., Carey, M., Love, A., Nehill, C., & Wein, S. (2006). 'Would you like to talk about your future treatment options'? discussing the transition from curative cancer treatment to palliative care. *Palliative Medicine*, *20*(4), 397-406.