PURPOSE:

To define guidelines for the withholding or withdrawing of life support measures.

POLICY:

The following guidelines are intended to be advisory in nature.

NURSING RESPONSIBILITIES:

It is the responsibility of all registered professional Nursing Staff to be acutely aware of the policy on withdrawing or withholding life-sustaining treatment in its entirety and to monitor Helen Newberry Joy Hospital and Healthcare Center's compliance.

SOCIAL SERVICE /NURSING RESPONSIBILITIES:

* Offer emotional support to family.
* Offer Pastoral service.
* Make referrals to a support group if family is interested. Assist family in locating appropriate mortuary.

GENERAL CONSIDERATIONS:

The withdrawal or withholding of life-sustaining measures shall be considered only when the proposed treatment is disproportionate in terms of benefits to be gained versus the burdens caused.

* Proportionate treatment is that which, in the view of the patient (or his/her surrogate), has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment.

* The determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely how long the treatment is likely to extend.
WHO SHALL DECIDE:

There are four categories of persons who should, or may, be involved in authorizing and/or implementing decisions to withhold or withdraw life-sustaining treatment, and in making a decision that treatment is disproportionate.

- Patient’s Physician and Consulting Physician:
  
  * The medical diagnosis and prognosis must be determined by the treatment and consulting physicians under the generally accepted standards of medical practice in the community.
  
  * Confirmatory opinions may be sought when they will help to more clearly assess a patient’s medical condition or substantiate a decision, and are not required to confirm the treating physician’s diagnosis or prognosis. Mandatory consultation requirement is not established.

- Patient:

  The right of a competent patient to direct the withholding or withdrawal of life-sustaining procedures in the event such patient is suffering from a terminal illness or condition is expressly recognized in the National Death Act, Health and Safety Code, Section 7185, et seq.

  * Special exception when patient is pregnant.
  
  * No order to discontinue life-sustaining treatment should ever be issued when a competent patient disapproves of the order.

- Parent, Guardian, Attorney-In-Fact, Conservator:

  * When a patient is incapable of making a decision regarding the use of life-sustaining procedures because of his/her medical condition or for other reason, a surrogate decision-maker should be consulted.

  * Selection of surrogate decision makers who may act on behalf of an incompetent patient should be guided by the principles of who may give consent as defined by law (see policy on consents). A Durable Power of Attorney for Health Care or other Patient Directives, if in effect, will be used. (See policy on Patient Directives.)
• Consultation with the Patient's Family and Significant Others:
  
  * The patient’s family and significant others should be consulted in all cases, even if a competent patient or his/her legal representative has authorized termination of life-sustaining treatment.
  
  * Whenever an attorney-in-fact, conservator, guardian, or family member disagrees with a decision to discontinue treatment, Helen Newberry Joy Hospital and Healthcare center should determine whether court authorization for termination of life-sustaining treatment should be sought.

• Special circumstances calling for consultation with Helen Newberry Joy Hospital and Healthcare Center's administration include:

  * When the patient’s condition has resulted from an injury which appears to have been inflicted by a criminal act, or
  * Has been created or aggravated by medical accident, and
  * Those in which the patient is pregnant, or
  * A parent with custody or responsibility for the care and support of young children.

**DO NOT RESUSCITATE ORDERS:**

• A "Do Not Resuscitate" order may be considered when the patient has:

  * A terminal condition,
  * Does not have any reasonable conceivable possibility for recovery or long-term survival, and
  * There is no medical justification or purpose which would be achieved by the application of cardiopulmonary measures.

  * CPR will automatically be initiated if there is no signed order for a “Do Not Resuscitate”.

  **The order for “Do Not Resuscitate” does not include the termination of IV therapy, medication, or feeding.**

  * The order for “Do Not Resuscitate” does not alter the basic nursing care needs of the patient.
PROCEDURE FOR ISSUING ORDER FOR WITHHOLDING OR WITHDRAWING OF LIFE SUPPORT:

* The "Do Not Resuscitate" order or the order to withdraw life support measures must be written on the physician's order sheet, dated, signed by the physician, and timed.

* In cases where death is imminent and the physician is unavailable to write a "Do Not Resuscitate" order, two registered nurses may accept a telephone order for "Do Not Resuscitate". This is to be documented on the physician's order sheet with time, date, and the signatures of the nurses receiving the telephone order. It is the physician’s responsibility to sign the order and record appropriate documentation in the progress notes within 24 hours.

* An order for a "chemical code," "partial code," or any other order that does not state "Do Not Resuscitate" is not acceptable and must be clarified with the physician.

* The order to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the progress notes of the circumstances surrounding the decision. Such documentation must include but is not limited to:

  * A summary of the medical situation which specifically addresses and refers to:
    1) the patient’s mental status
    2) the diagnosis
    3) prognosis at the time the order is written, or the decision is made to test results (either current or previously performed, or an explanation, if tests are not performed)
    4) The outcome of any consultations with other physicians. (Physicians who provide consultations must document their consultative finding and recommendations. A consultant with the approval of the attending physician may write a “Do Not Resuscitate” order which must be documented and discussed with the patient’s family as noted above. To do so, the consultant must document in the medical record that he/she has obtained such approval to write the “Do Not Resuscitate” order from the attending physician.)
    5) A statement indicating that basis upon which a particular person(s) have been identified as appropriate surrogate decision maker(s) for the patient, i.e., Durable Power of Attorney. A Statement summarizing the outcome of consultations with the patient, parent, guardian, attorney-in-fact, conservator, family, or significant others.
If any such person not having specific legal authority to make decisions for the patient does not concur with the decision, person(s) opinions are believed not to be sufficient reason to preclude the withdrawal or withholding of the treatment in question.

* Only the patient's physician (attending or consulting) shall be responsible for disconnecting medical devices (i.e., ventilators).

* Every necessary procedure should be performed to relieve the patient's suffering and to maintain the patient's comfort.

* Consideration for the withdrawal of life support measures may include documentation of brain death by EEG, no less than two (2) times, prior to the time the order is taken.

* Each admission process will require re-evaluation of a patient's CPR status and a new order will be written and a new consent form will be signed.

**PROCEDURE:**

I. The physician will determine etiology of depressed brain function.

   A. Rule out effects, which may artificially depress brain function:

      1. Central nervous system depressant drugs: tricyclic antidepressants, barbiturates, opiates, neuromuscular blocking agents, phenothiazines, and recent general anesthesia

      2. Metabolic imbalances: i.e., hepatic or diabetic coma, severe electrolyte imbalances

      3. Hypothermia: i.e., core temperature less than 32.2 C or 91 F

      4. Hypotension: i.e., systolic blood pressure less than 90 mmHg

      5. Central nervous system infection

      6. Shock
B. Identify the specific cause mechanism, which has resulted in the loss of brain function:

1. CVA: i.e., AVM, ruptured aneurysm, spontaneous bleed
2. Direct trauma: i.e., assault, fall, gunshot wound
3. Anoxia: i.e., drowning, cardiac arrest, drug overdose

II. Determine existence of neurological deficits:

A. Areflexia: Absence of purposeful motor movement to deep pain applied to the digits, sternum, and/or supraorbital region. (Note: In many cases spinal cord reflexes are preserved following brain death. Rule out cervical spinal cord injury prior to areflexia testing of lower spinal cord levels.)

B. Pupillary: Absence of change in pupil size when light is shined into eyes. (Note: Rule-out eye trauma or ocular disease prior to testing.)

C. Ocular: Absence of doll’s eye reflex when head is tilted forward 30 degrees and rapidly turned from side to side. (Note: Rule out trauma or ocular disease prior to testing.

D. Caloric: Absence of caloric reflex with 10 cc of ice water irrigation in both external ear canals. (Note: Rule out pre-existing labyrinthine disease and/or the ototoxic effects of amino glycoside antibiotics.)

E. Corneal: Absence of eyelid movement when both corneas are touched with a piece of cotton. (Note: Rule out pre-existing facial muscle palsies.)

F. Gag: Absence of uvula movement of gagging when a tongue depressor is applied to the posterior areas of the tongue and pharynx.

G. Cough: Absence of coughing when the tracheobronchial tree is stimulated by a suction catheter being placed down the endotracheal tube followed by a 10 cc sterile NaCl irrigation.
PROCEDURE CONTINUED

H. Apnea: Absence of any spontaneous respiratory drive following:

1. Baseline Arterial Blood Gas (ABG) immediately prior to Apnea Test.

2. 10 minutes of pre-oxygenation with 100% FiO2.

3. 100% oxygen passive delivery system by way of endotracheal cannula inserted to a point 2-3 cm above the carina and delivered at a rate of 3-4 liters/minute.

4. Arterial blood gases (ABG’s) with PaCO2 > 60 mmHg or other hospital specific formulas such as 20 mmHg above baseline (Note: If hypotension or cardiac arrhythmia develop, the ventilator should be reconnected immediately, and other confirmatory testing considered.)

III. Determine continued presence of neurological deficit after a period of time consistent with the etiology of brain injury. This time frame should be no sooner than one hour from the previous neurological exam and no later than 24 hours. Longer periods of observation should be considered for patients under 5 years of age.

IV. Certification: the written brain death declaration note should include the following:

A. Date of death (day, month, and year)

B. Time of death (hour and minute)

C. A definitive statement of declaration (i.e., “Patient is pronounced dead.”)

D. Description of method(s) used to make this determination

E. Signature of physician making declaration.
DISPUTE RESOLUTIONS:

* In the event that a dispute arises concerning the issuance of an order to withhold or withdraw treatment, the matter will be referred to the Ethics Committee for review.

* All life-sustaining treatment will be maintained until resolution of the dispute has been reached.

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