



**NEPHROLOGY PROGRAM
DEPARTMENT POLICIES AND PROCEDURES**

**Hemodialysis - Section 03 - Patient Assessment & Management - Neph 3-16
Advance Care Planning - DNR
No.: 01364 (TOH Standardized Policy Number)**

ISSUED BY:

Advance Directives Committee /
Hemodialysis Clinical Practice

DATE OF APPROVAL:

N/A

APPROVED BY:

Nephrology Steering Committee

LAST REVIEW/REVISION DATE:

2014/06

CATEGORY:

Patient Assessment and Management

IMPLEMENTATION DATE:

2006/03

PURPOSE:

- To ensure that all patients have had the opportunity to express their wishes for continuing/withdrawing treatment should their medical condition change
- To ensure that the Nephrology program has the necessary information to contact the Substitute Decision Maker (S.D.M.) or Next of Kin
- To ensure that patients have the opportunity to discuss and understand DNR (Do Not Resuscitate) status, and that any decisions about this are clearly documented on the chart
- To ensure the documentation related to the Advance Care Planning (ACP) and/or DNR are readily available in the patient's chart through standardized documentation

BACKGROUND STATEMENT :

- Advance Care Planning is not mandatory, but encouraged, as Chronic Kidney Disease has no cure. We can provide treatment (Hemodialysis, Peritoneal Dialysis or Transplant) and it is ultimately the patient's decision to start, continue or withdraw/refuse treatment. If the patient is unable to make this decision, this decision falls to the S.D.M. or Next of Kin
- Life expectancy and quality of life aspects vary from patient to patient and is difficult to predict
- Families/SDMs can make better decisions related to care if they know the patient's wishes and beliefs. Patients can make better decisions if these issues are discussed

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openly. This communication process can be aided by discussion of Advance Care Planning (including Living Wills, Advance Directives)

- Patients may change their minds about their decisions at any time
- By making this a routine topic of discussion, the patient will not feel that he/she is being singled out due to medical reasons, and that the patient should be in charge of deciding his/her treatment
- Patients may decide not to discuss end-of life issues or complete Advance Care Planning, but may wish to be considered DNR in the event of cardiac or respiratory arrest
- Care must be taken to respect cultural background and religious beliefs, although this should not preclude asking the patient about Advance Care Planning

SUPPLIES:

- Advance Care Planning handout
- POA form

DEFINITION(S): N/A

ALERTS: N/A

PROCEDURE:

1. All patients will be asked if they have a Living Will, Advance Directives or Advance Care Planning and this will be documented. This may occur in PRI Clinic or when starting treatment (Hemodialysis, P.D. or Transplant workup)
2. If the patient has a SDM, obtain the name and contact information of the SDM and document on chart. If there is no SDM, obtain the name and contact information of Next of Kin and document
3. Patients who do not have Advance Care Planning will be provided with the information package. Ideally, this should be done before the patient starts treatment but, having failed that, should be done within a month of starting treatment
4. This information may be provided by the Social Worker, Nurse or Physician. Summary of this discussion is to be documented in NephroCare or in the patients chart for those areas not using NephroCare
5. Advance Care Planning decisions are to be reviewed/validated q 6 months

DOCUMENTATION:

Section A: For DNR documentation:

For the nephrology units that do not document in NephroCare

- Follow corporate DNR policy- Physicians to write order and progress note
- DNR status is to be documented on the patients Care Plan in Red ink, along with the date

For the nephrology units that have NephroCare the DNR status will be documented in NephroCare as a Physicians order.

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- a. This is the process that the physician follows to create a DNR order.

The physician

- Opens the Directives/ Orders Screen
- Clicks the New button
- Toggles the “Resuscitation No” toggle (which communicates that information the pertinent areas of the chart)
- Notes the statement “In the event of a cardiac arrest do not attempt resuscitation” in the order detail and types additional comments in the detail box as required.
- Save and Close the screen
- Types a progress note explaining the conditions/ conversation that **supports this order.**

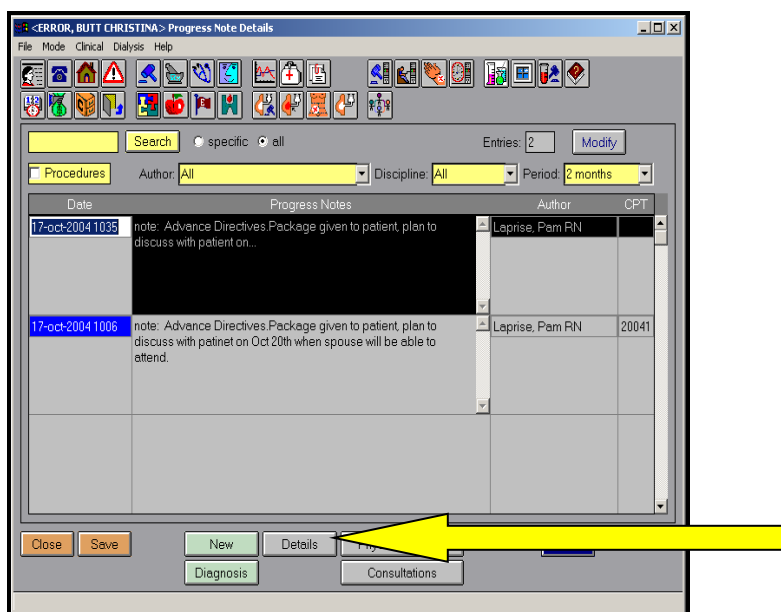
The nurse:

- Acknowledges the order
- b. For inpatients **with a DNR order on their** Ottawa Hospital inpatient chart.
- The RN will ask the rounding Physician to write a progress note **and DNR order into NephroCare as outlined above in a)**
 - The RN will then acknowledge the order
- c. When processed, “Resuscitate No” appears on the Nurses Worksheet and R68 Patient Care Summary.

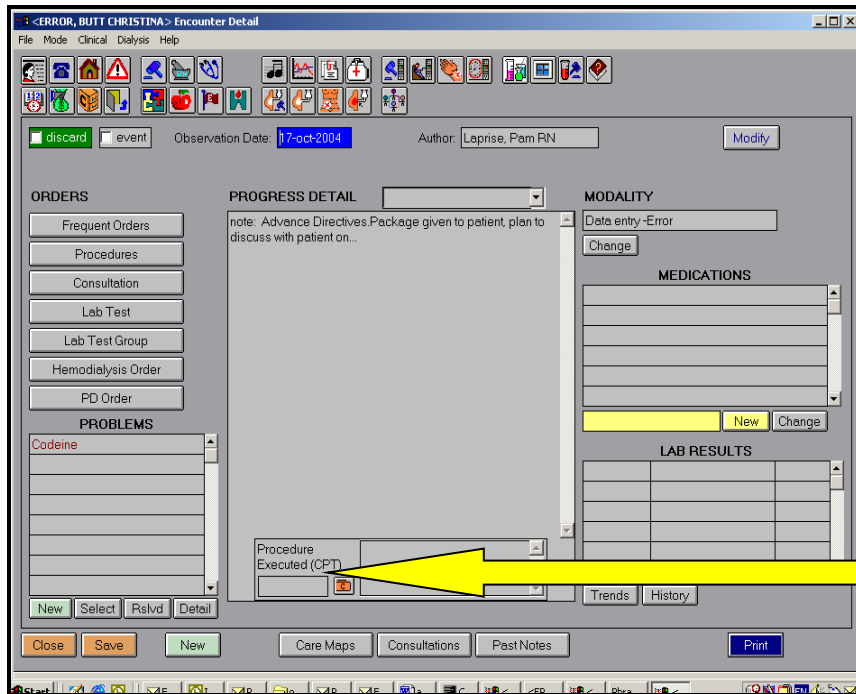
Section B: For Advance Directive Documentation:

1. For the nephrology units that do not document in NephroCare
 - a. The name, contact information and relationship (if different from next of kin) of the substitute decision maker will be documented on the nursing Kardex
 - b. Write “Advance Directives” on the nursing Kardex along with the date. A dated summary of all Advance Directive discussions will be documented in the progress notes.
 - c. If possible, obtain a copy of the POA form and Advance Directives and place on chart- ensure patient is aware that he/she needs to bring AD anytime he/she comes to hospital as information on our chart may not be accessible to other areas in the hospital
2. For the Nephrology units using NephroCare
 - a. The “substitute decision maker” is listed as a contact in the contacts section of NephroCare. Phone number(s) are listed. Details related to the person are entered in the comment section, especially if the substitute decision maker is not the Next of Kin. If possible, obtain a copy of the POA form and place on chart.
 - b. The record of all A.C.P. discussions are contained in a Progress Note.
 - From the main menu, highlight the patients name and click on the **Progress Note** icon (musical notes) or click on the Treatment menu, Progress Notes item.
 - Click **New**
 - From the **Phrase Selection** screen, choose one of the following:

- A.D. Package given which will have the following text: Advance Directives package given to patient, plan to discuss further with patient on (fill in details).
- A.D. Discussion which will have the following text: Met with patient and ..., in (location) ..., Family situation:..., Religious beliefs:..., Patient competency:..., A.D. for DNR and other scenarios:..., Patient aware of reversibility:..., Discussion with family:..., Response to discussion:
- Add text or delete some of the phrase text. Click Save. Click Details to open the Encounter screen



- In the Encounter screen click on the **Procedure Executed (CPT)** catalogue. Scroll through the list and *select Advance Directives*. Now that a procedure is associated with the note, this documentation can be included in a follow-up report. Continue to document the progress note if desired.
- Save and Close



- To obtain a report of Advance Directives notes:
 - Print report R1925 Advanced Directives – Procedure Notes report outlines # of patient’s that had discussions re A.C.P. along with the progress note.
 - Print report R2162 Advance Directives- reports only the site, patients name, and author of note, but does not print the actual progress note associated with the entry

- c. If possible, obtain a copy of the POA form and Advance Directives and place on chart, ensure patient is aware that he/she needs to bring AD anytime he/she comes to hospital as information on our chart may not be accessible to other areas in the hospital

RELATED POLICIES / LEGISLATION: N/A

REFERENCES:

1. Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis. (Feb. 2000) Renal Physicians Association and American Society of Nephrology Clinical Practice Guideline
2. Advanced Care Planning working Group (TOH)

COMMENTS / SIGNIFICANT REVISIONS: N/A