# 14-191 DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Chapter 3 RULES REGARDING THE USE OF DO NOT RESUSCITATE (DNR) ORDERS IN DEPARTMENT INSTITUTIONS

 PURPOSE:

 The general policy of the Department of Mental Health and Mental Retardation is to provide the highest quality medical care to its patients with the objective of sustaining life and practicing medicine in conformity with highest ethical and medical standards. A standing order exists in all department institutions to initiate CPR\* for patients in unanticipated need of resuscitation because CPR is often invaluable in the prevention of sudden, unexpected cardiac or respiratory arrest. For most patients, CPR should and is administered because there is a reasonable medical expectation of effecting a permanent or temporary cure of or relief from the illness or condition being treated. But the advisability of CPR cannot always be presumed. A Do Not Resuscitate ("DNR") order may be appropriate when, for example, resuscitation would be unsuccessful in restoring cardiac or respiratory function or when the prognosis of a patient is hopeless, death is expected as part of the natural course of the disease process and revival (resuscitation) from apparent death would only temporarily prolong the agonal state.

 Every patient admitted to a department institution shall be presumed to consent to be resuscitated in the event of cardiac or respiratory arrest unless there is consent to the issuance of an order not to resuscitate as provided in these rules. A competent and informed adult patient has the right to direct the course of his own treatment, so be may decide, in conjunction with his physician, to have CPR withheld in the event of cardiac or respiratory arrest. An appropriate surrogate nay also choose to forego resuscitation on behalf of a dying incapacitated patient.

 These rules set out standards under which an order to withhold CPR may be entered by an attending physician with the consent of a competent patient, or, in the case of an incapacitated patient, with the approval of an appropriate surrogate.

 DEFINITIONS

“Terminal Condition” means a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, there Is no recovery and which reasonably can be expected to cause death within one year.

“Medically contraindicated” means, to a reasonable degree of medical certainty, that CPR will be unsuccessful in restoring cardiac and respiratory function, or that the patient will experience repeated arrest in a short time period before death occurs or that CPR would impose unwarranted physical trauma on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient.

\*"CPR" is an abbreviation for cardiopulmonary resuscitation: a basic life support technique used to revive a patient when cardiac or respiratory arrest is detected. The procedure includes removing obstructions to the airway, attempting to restore breathing, and performing closed chest compression to restore the heart beat.

“Capacity” means the ability to understand and appreciate the nature and consequences of an order not to resuscitate, after having been provided with information regarding the risks, benefits and alternatives of such an order and the ability to make or communicate an informed decision with respect to resuscitation.

“Staff” means physicians and other health care providers employed by the department to provide care in department institutions.

“Attending physician” means the physician who has the primary responsibility at any given time for the treatment and care of a patient.

“Health care provider” means a person who is licensed, certified or otherwise authorized by the law of Maine to administer health care in the ordinary course of business or practice of a profession.

“Department institution(s)” means the Bangor Mental Health Institute, the Augusta Mental Health Institute, Pineland Center, the Aroostook Residential Center, and the Elizabeth Levinson Center.

“Medical Record” means the current and, where appropriate, permanent medical record of a patient.

“DNR order” means an order entered into the order sheet of the medical record of a patient signed and dated by the attending physician directing that no attempt be made by staff to resuscitate the patient should cardiac or respiratory arrest occur.

“Reasonably available” means that a person to be contacted can be contacted with diligent efforts by an attending physician or another person acting on behalf of the attending physician or the Institution.

POLICY :

I. CAPACITY TO MAKE CPR DECISION

 Every adult patient shall be presumed to have the capacity to make a decision regarding CPR unless determined otherwise pursuant to these rules or pursuant to court order. A lack of capacity shall not be presumed from the fact that a guardian has already been appointed.

II. COMPETENT ADULT PATIENTS

 Competent adult patients have the right to make decisions concerning their own medical treatment. If an adult patient expresses a desire to not be resuscitated under specified medical conditions after. discussion with his physician, that physician shall write a DNR order for such patient provided he has determined, to a reasonable degree of medical certainty, that such medical conditions exist and the patient is competent to make an informed-decision with respect to the issue. A second physician or licensed clinical psychologist not involved in the patient's treatment must concur with the attending physician's conclusion with respect to the issue of capacity. The opinions with respect to the capacity of the patient and the patient's consent to a DNR order shall be in writing and shall be filed in the medical record of the patient. The clinical director or equivalent shall be notified of any such DNR order prior to its entry. If a patient determined to have capacity to make a CPR decision with a guardian consents to a DNR order, the guardian's consent must also be obtained prior to the entry of the order. If such a patient expresses a wish to be resuscitated, his wishes are controlling.

III. ADVISABILITY OF CPR IN LIGHT OF THE MEDICAL CONDITION OF PATIENT

 A. Medical Condition

 CPR, as a standing order, is based an the presumption of potential medical benefit to the patient, outweighing the potential for causing physical and mental injury. The presumption of benefit to the patient no longer applies when the physician determines and documents that the application of CPR is not justified because the patient is either in a terminal condition or because CPR is medically contraindicated.

COMMENT

 The prognosis of terminality may arise when an underlying condition, such as end stage cancer, or end stage Alzheimer's disease is considered to be medically incurable or untreatable in terms of currently available technology and where death as a result of the natural history of the disease process or medical problem will likely occur within one year. CPR may be medically contraindicated when resuscitation is likely to not only be ineffective in restoring normal functioning but might also induce a state of prolonged pain and suffering.

 D. Discussion with Others

 Because of its grave nature and consequences, a DNR decision should be made under conditions that permit consultation and reasoned decision making by all parties involved. Prior to and after the entry of a DNR order, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the hospital staff, especially the nursing staff, so that all involved professionals understand the order and its implications. Each institution shall develop a procedure to resolve staff disagreement concerning the entry of a DNR order for a particular patient.

 When a physician believes that a patient is either in a terminal condition or that the patient's condition Is such that CPR is medically contraindicated, he shall request a separate evaluation of the patient's medical condition from another physician. If the second evaluation confirms the first, the physician shall then attempt to discuss the issue of CPR with the patient to determine the patient's wishes.

 C. Prior Consent

 A physician shall obtain authorization from an appropriate party or from an advance directive of the patient prior to the entry of a DNR order.

 (1) Decision making by patient with capacity

 A patient who is determined by his attending physician to have the capacity to make a decision with respect to resuscitation and who is in a terminal condition or whose condition is such that CPR is medically contraindicated, shall be fully informed of the risks, benefits and alternatives of a DNR order by his attending physician. The consent of such patient shall be obtained in writing prior to the entry of a DNR order in the record by the attending physician.

 If a patient with a guardian is determined to have the capacity to make a decision with respect to CPR, the guardian shall be notified and his consent also obtained prior to the entry of a DNR order in the medical record. If such a patient expresses a wish to be resuscitated, his wishes are controlling.

 If the patient has no objection, family members who are reasonably available should be informed of a DNR order by the attending physician or a staff member acting on his behalf and every effort shall be made to involve such members. However, the wishes of the patient are controlling. If the patient does not wish family members contacted the patient's privacy shall be respected and the patient's wishes shall be documented in the record.

 If a patient with capacity later becomes incapacitated, an advance directive (prior written consent, a living will or a durable power of attorney) of the patient with respect to CPR shall be honored by the attending physician.

 (2) Decision making for Incapacitated Patient

 If the attending physician has attempted to discuss the issue of resuscitation with the patient and has concluded that the patient is incapacitated, he shall obtain a second opinion on the issue of capacity from a physician or licensed clinical psychologist who is not involved in the treatment of the patient. If the second opinion fails to find incapacity, the procedure outlined in Section III (C)(1) above shall be followed. If the second opinion affirms the physician's finding of incapacity, the attending physician shall discuss the issue of resuscitation with an appropriate surrogate.

 (a) Surrogates

 One person from the following, to be chosen by the attending physician or designee in order of priority stated, when a person in the prior class is not reasonably available, willing or competent to act, shall have the authority to act as surrogate for decision making on behalf of an incapacitated patient:

 an agent appointed by the patient under it durable power of attorney for health care decision making;

 a legal guardian or legally responsible parent of the patient.

 COMMENT

 Power of Attorney

 A properly executed durable power of attorney may be used in Maine to make health care decisions on behalf of an Incapacitated person. A document purporting to grant this type of authority to another must 1) specifically state that the power outlasts the disability of the principal (the person on whose behalf the agent acts), 2) specifically grant to the agent the power to sake health care decisions and 3) must be notarized. The agent continues to have this authority even if a guardian is subsequently appointed. (A court would have to formally terminate this type of power of attorney.)

 Guardian

 The extent of the guardian's power should be carefully determined. Some guardians have limited power over the ward's personal affairs. Note also that a conservator does not have the power to make personal health care decisions on behalf of his/her ward.

 Minors

 An emancipated minor is legally competent to make medical treatment decisions. An unemancipated minor is legally incompetent to make most treatment decisions -- that right rests with his legal guardians) which in most cases is his parent(s). Nevertheless, the attending physician should in every case attempt to discuss the issue of CPR with a minor patient as well as with his guardian. If a minor patient is unable to understand or communicate his/her wishes, his guardian may make the decision as the appropriate surrogate. However, if a minor patient is able to express an opinion with respect to this decision, his wishes shall be given great weight. If a minor patient wishes not to be resuscitated, the legal guardian of the minor must also consent prior to the entry of a DNR order. If the minor patient expresses a desire to be resuscitated but the legal guardian consents to a DNR order, no DNR order may be written without court order.

 (b) Standard for surrogate decisions

 The attending physician shall inform the surrogate of the patient's diagnosis, prognosis, the risks, benefits and alternatives to CPR and shall provide any other information necessary so that the surrogate can make an informed decision regarding the use of resuscitation for the patient. The surrogate's decision regarding CPR should be based on an understanding of the patient's previous or current known wishes or, if the patient's wishes are unknown and cannot be ascertained, on the basis of the patient's best interests. The physician shall inform the surrogate of any explicit verbal or written directives of the patient on the issue known to the physician. The surrogate should make a good faith effort to involve all concerned family members In a CPR decision. The physician shall obtain the written informed consent of the surrogate prior to the entry of a DNR order in the patient's medical record. In an emergency, when the surrogate is unable to be physically present, verbal consent immediately followed by consent in writing shall serve as authorization for a DNR order. -

IV. RELATED MEDICAL CARE

 A DNR order is compatible with maximal therapeutic efforts short of resuscitation and the patient shall receive support in all other therapeutic modalities available and medically appropriate even though a DNR order is in place. Medical efforts which will be maintained to relieve suffering and assure patient comfort shall be written on the order sheet. Such efforts may include, without limitation, basic nursing care, antibiotics, the heimlich maneuver to prevent choking, adequate analgesia, suction and intake for comfort including nutrition, hydration and oxygen.

V. MONITORING

 Staff shall monitor the patient's condition on at least a daily basis and report any change to the attending physician. The attending physician shall conduct a thorough and formal review of the condition and capacity of the patient at least every 90 days to determine if a DNR order is still appropriate in light of the patient's condition. Such review shall include consultation with other treating staff. Progress notes shall reflect this periodic review. If a significant change in condition does occur, the physician shall notify the patient, if possible, or the patient's surrogate of such change. Each institution shall attempt to obtain a reaffirmance of the initial consent to a DNR order after each reevaluation but, in any event, at least every 90 days. Each institution shall be responsible for obtaining new authorization should the appropriate surrogate change.

VI. ENTRY AND NOTICE OF DNR ORDER The attending physician shall ensure that all DNR orders are written, signed, dated and entered into the medical record of the patient. At the time a DNR order is written, a companion entry should be made in the progress notes which includes at least: the diagnosis, prognosis of the patient, the patient's known wishes, the wishes of the patient's surrogate and the recommendations of named members of the treatment team. There should also be documentation supporting the finding of competency or incapacity of the patient and the written consent of the patient or his surrogate. No verbal or telephone orders to forego resuscitation shall be made. The DNR status of the patient shall be prominently noted or displayed at all times for the benefit of staff.

 If a DNR order is discontinued due to a change in the patient's medical condition, the attending physician shall ensure that a dated and signed order to cancel and an explanatory note shall be written in the record. He shall also ensure that the patient, if possible, or his surrogate is informed of the rescission of the order. A new attending physician shall conduct his own review of the patient's condition and shall write his own order based on this review. If be believes that the existing DNR order should be discontinued for reasons other than a recent change in the patient's condition, he shall initiate the procedure for resolution of staff disagreement. If a decision is made to discontinue the DNR order, the procedures for discontinuance as outlined above shall be observed.

VII. NOTICE TO OFFICE OF ADVOCACY

 The Advocate shall be notified at the time a second opinion regarding capacity is requested (when a DNR order is initially contemplated) and at the time a DNR order is written or rescinded.

VIII. TRANSFER OF PATIENT

 In the event that a patient with a DNR order is transferred within an institution or is transferred to another medical facility, the attending physician shall notify appropriate internal staff or staff of the other medical facility of the existence of a DNR order.

 Each institution shall develop its own procedures to comply with this protocol and shall submit these procedures to the department for approval.

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