

## **Title: Resuscitation Policy: Code Status and Do Not Attempt Resuscitation (DNAR) Orders**

### **I. POLICY**

It is the policy of [HOSPITAL NAME] to provide resuscitative efforts, including but not limited to cardiopulmonary resuscitation (CPR), for all patients when their cardiovascular, respiratory or other systems fail unless the Physician of Record has written a Limited Cardiopulmonary Resuscitation (LCPR) or Do Not Attempt Resuscitation (DNAR) order. Orders to limit or withhold resuscitative interventions must be made in accordance with this Policy, and no other orders for such purposes may be authorized or implemented (e.g., “slow codes” are not permitted).

### **II. DEFINITIONS**

- A. *Physician of Record* – a member of the Medical Staff who, without reference to Medical Staff membership category, is the principle provider of professional services to the patient during hospitalization and directs the care for that patient during the course of the stay as evidenced by signed written orders and progress notes.
- B. *Legal Representative* – an individual authorized to make healthcare decisions for a patient due to appointment by the Courts to be the patient’s Conservator or designated in a Power of Attorney for Health Care (or other legally-recognized advance medical directive) to be the patient’s Agent or Attorney-in-Fact.
- C. *Surrogate* – an adult, other than a Legal Representative, recognized to make decisions for the patient.
- D. *POLST* – a “Physician Orders for Life-Sustaining Treatment” form, approved by the California Legislature, which indicated previously ordered medical interventions to be provided for a patient (based on, at the time of completion, the patient’s medical condition and preferences) for which the patient or the patient’s Legal Representative or Surrogate is responsible to present to staff upon admission.
- E. *Cardiopulmonary Resuscitation (CPR)* – the administering of any measures or devices intended to restore or support cardiac and/or pulmonary functions in a patient, by means of ventilatory assistance (manual or mechanical), cardiac massage, chest compression, cardioversion, administration of pharmacological agents, or other procedures when cardiac or respiratory arrest has occurred or is believed to be imminent.
- F. *Code Status* – designation of resuscitative efforts, if any, that are to be attempted when a patient suffers a cardiopulmonary arrest. For the purposes of this Policy, there are three categories of Code Status:
  - 1. *Full Code or Code Blue* –all appropriate resuscitative measures, including CPR, shall be attempted.
  - 2. *Limited Cardiopulmonary Resuscitation (LCPR)* –only specified methods of attempted

resuscitation shall be attempted.

3. *Do Not Attempt Resuscitation (DNAR) or No Code* –no resuscitative measures shall be attempted.

### **III. PURPOSE**

The purpose of this Policy is to provide guidelines for determining the appropriate use or withholding of resuscitative measures and for implementing orders to limit or withhold such measures.

### **IV. PROCEDURE**

#### *A. Steps to determine Code Status – General requirement for consideration for all patients/all admissions*

It is recommended that upon a patient's admission, the Physician of Record (or designee) clarify the patient's goals for treatment and hospitalization, and note them in the medical record as soon as possible. It is important that the Physician of Record (or designee) clarify the patient's values, preferences and minimally acceptable outcomes. For patients who are in an irreversible coma or persistent or permanent vegetative state, the Physician of Record (or designee) must indicate the patient's Code Status within twenty-four hours of admission or establishment of the diagnosis.

#### *B. Procedures Pertaining to Consideration and Implementation of LCPR and DNAR orders.*

##### **1. ADULT WITH CAPACITY TO MAKE INFORMED DECISION**

If the patient is an adult and is capable of making an informed decision, the Physician of Record (or designee) must discuss his or her recommendations with the patient regarding Code Status, outlining the risks, benefits, and probable outcomes of resuscitative efforts in the event of a failure of the patient's organs or systems. When the patient requests an LCPR or DNAR order, the Physician of Record (or designee) shall make every effort to honor the patient's preference. Discussion between the Primary Physician and the patient should be pursued to determine whether or not resuscitation is of benefit in consideration of such factors as:

- Relief of suffering;
- Preservation of life;
- Likelihood of restoration of function, and
- The quality and extent of sustained life.

The Physician of Record (or designee) may elect to transfer the patient to a physician who is willing to comply with the patient's preferences.

##### **2. ADULT LACKING CAPACITY TO MAKE AN INFORMED DECISION**

###### **a. Advance Directive or POLST**

If the patient lacks capacity to make an informed decision, the Physician of Record (or designee) must rely on any valid written legal document which explicitly discusses code status, including an Advance Healthcare Directive or POLST form.

###### **b. No Advance Directive or POLST**

If the patient lacks capacity to make an informed decision and has no Advance Directive or POLST form which adequately addresses the patient's Code Status, the Physician of Record (or designee) must then discuss his or her recommendations

regarding Code Status with the patient's Legal Representative or Surrogate and institute the Code Status determined in a manner provided by this policy.

When the Legal Representative or Surrogate requests a LCPR or DNAR order, the Physician of Record (or designee) shall make every effort to honor the Legal Representative or Surrogate's preference. Discussion between the Physician of Record (or designee) and the patient's Legal Representative or Surrogate should be pursued to determine that the request is consistent with the patient's expressed values and whether or not resuscitation is of benefit in consideration of such factors as:

- Relief of suffering;
- Preservation of life;
- Likelihood of restoration of function, and
- The quality and extent of sustained life.

The Physician of Record (or designee) may elect to transfer the patient to a physician who is willing to comply with the Surrogate's preferences.

#### c. No Advance Directive or POLST and No Legal Representative or Surrogate

If the patient lacks capacity to make an informed decision and has no Advance Directive or POLST form and has no Legal Representative or Surrogate, the Physician of Record (or designee) must institute a Code Status in keeping with the patient's best interest. In determining the patient's best interest, the Physician of Record (or designee) must consider the patient's personal values to the extent known to the Physician of Record (or designee). It is highly recommended that the physician consult with a colleague and/or obtain a Clinical Ethics Consultation to assist with decision-making utilizing a burdens vs. benefits analysis.

### 3. MINOR WITH CAPACITY TO MAKE INFORMED DECISION

Although minors (under the age of 18 years) are generally considered to lack the legal capacity to make medical decisions by virtue of their age, if they understand the nature and consequences of a decision to forego life sustaining treatment then they should be viewed as a competent minor, and the minor should be included in Code Status discussions. Life sustaining treatment should not be withheld from a competent minor unless the minor and the minor's Agent or Surrogate(s) agree with the decision.

### 4. MINORS WITHOUT CAPACITY TO MAKE INFORMED DECISIONS

The Physician of Record (or designee) must discuss his or her recommendations regarding Code Status with patient's Legal Representative or Surrogate and institute the Code Status determined in a manner provided by this policy and policies pertaining to infants, including specifically, Medical Center's Policy regarding "Withholding and Withdrawal of Life Sustaining Treatment."

## 5. CONDITIONS IN WHICH RESUSCITATION ATTEMPTS ARE CONSIDERED MEDICALLY INAPPROPRIATE

In the following circumstances, resuscitative measures are generally deemed to be medically inappropriate because either they provide no direct benefit to a patient or cause more harm than actual or reasonably expected potential benefits:

- a. The patient's death is imminent as determined by the Physician of Record (or designee).
- b. The patient has a condition in which resuscitation would only prolong the dying process that the Physician of Record (or designee) determines is already irreversibly underway.
- c. Resuscitative measures are judged by the Physician of Record (or designee) to offer no reasonable expectation of achieving the physiological effects for which they would be used, e.g., they are judged to be medically ineffective.
- d. The patient has a medical condition for which the Physician of Record (or designee) does not expect resuscitation efforts to achieve the patient's minimal acceptable outcome as expressed by the patient or as determined by the patient's Legal Representative or Surrogate in the patient's best interests (examples of minimal acceptable outcome would be restoring physical function of the organs, returning to a pre-morbid baseline, or achieving a certain activity of daily living or quality of life).
- e. The patient has an irreversible, incurable or terminal condition in which the Physician of Record (or designee) determines that resuscitation would impose burdens greatly disproportionate to any expected patient benefit.

Under the above circumstances, the Physician of Record (or designee) must write a Code Status order, e.g., Full Code, LCPR, or DNAR, in the patient's medical record. In addition, documentation in the patient's Progress Notes must be written (see section C below). When the basis for an LCPR or DNAR order is that resuscitative measures are judged to be medically inappropriate, discussion with the patient or the patient's Legal Representative or Surrogate (if the patient lacks decision-making capacity) must also occur; however, consent does not need to be affirmatively given since providing measures judged to be medically inappropriate is not standard of care.

In those circumstances in which a patient, or a patient's Legal Representative or Surrogate, insist on resuscitation efforts which the Physician of Record (or designee) has determined are medically inappropriate, Clinical Ethics Consultation is to be requested.

## 6. CODE STATUS IN OPERATING ROOMS/PROCEDURE AREAS/RECOVERY ROOMS WHEN AN ANESTHESIOLOGIST IS PRESENT

- a. For patients with LCPR or DNAR orders scheduled to undergo surgical or other

procedures that require the administration of the agents or application of the techniques of anesthesia, it is the usual practice to suspend the patient's LCPR or DNAR order for the duration the patient is in the operating room or procedural area, and then in recovery.

i. During this time period, the patient will be treated as if his or her Code Status is Full Code.

ii. If the patient has a purple color-coded wristband (see section C4 below), it will be removed by a nurse in the operating room or procedure area.

iii. At the conclusion of this time period, the patient's surgeon or proceduralist physician must reissue the LCPR or DNAR order. When the order is DNAR, a new purple color-coded wristband will be placed on the patient by the nurse.

b. In certain circumstances, it is permissible to continue a patient's LCPR or DNAR order for the duration the patient is in the operating room or procedural area, and then in recovery.

i. The Physician of Record (or designee) must pre-operatively/pre-procedure discuss code status with the patient or the patient's Legal Representative or Surrogate and decide whether to continue the LCPR or DNAR order for the time period when the patient is in the operating room or procedure area, and then in recovery.

ii. If the decision is to continue a patient's LCPR or DNAR order in the operating room or procedure area, and then in recovery, the Physician of Record (or designee) must obtain agreement from the surgeon or proceduralist physician (if different from the Physician of Record), and the anesthesiologist prior to going into the operating room or procedure area.

iii. Also prior to the patient going into the operating room or procedure area, the Physician of Record (or designee), surgeon or proceduralist physician (if different from the Physician of Record), anesthesiologist, and operating room or procedure area nurses must discuss and establish a management plan for continuing the LCPR or DNAR order. The surgeon or proceduralist physician must document this plan in the patient's chart.

iv. When the patient is taken into recovery, the surgeon and anesthesiologist must discuss the management plan with the recovery nurses and ancillary personnel.

### *C. Issuance of the Order*

#### 1. Written Orders

The Code Status order must be written on the Physician's Order sheet and accurately timed, dated, and signed by the Physician of Record (or designee). The order must be substantiated by an appropriate entry in the Progress Notes in accordance with the procedures set forth in section D below.

2. Telephone Orders

The Physician of Record (or designee) may give telephone Code Status orders as follows:

- a. Either two RN's or one RN and one LVN II must be on the call taking down the orders.
- b. Documentation in the patient's record (entered in the Physician's Order Sheet) must include:
  - i. Date and time of telephone order.
  - ii. Name and identification number of Physician of Record (or designee) giving the telephone order.
  - iii. Names and signatures of the two (2) RNs or one RN and one LVN II taking and witnessing the order.
  - iv. The Statement made by the physician regarding consultation with patient/family/significant other /legal representative regarding withholding of resuscitative effort. The statement may be entered in the patient's record (in the Progress Notes) in the following format:

[Date]

DNAR Order per telephone order of

\_\_\_\_\_ who states that  
Name of Physician of Record (or designee) Consultation with the  
patient and/or family/significant other/legal representative  
regarding whether the patient's desires regarding resuscitative  
efforts have been expressed or are otherwise known.

[[Add additional detail as dictated.]]

\_\_\_\_\_  
Name of RN Date Signature of RN

\_\_\_\_\_  
Name of RN/LVN Date Signature of RN/LVN

- 3. The Physician of Record (or designee) who gave the telephone order must countersign the telephone order within 24 hours of issuance.
- 4. Color-coded Wrist Band (Refer to Medical Center's Policy regarding "Patient Identification/Patient Wristbands")

When the Physician of Record (or designee) writes a DNAR order, a purple color-coded wrist

band will be applied to the same limb with the white patient ID wrist band.

The purple DNR wrist band will not be applied when an LCPR order is written.

#### *D. Documentation Supporting LCPR or DNR Orders*

1. When a patient's Code Status order is changed from Full Code to LCPR or DNAR, or when the Full Code order is for a patient with a medical condition in which attempt at resuscitation is considered medically inappropriate (as defined above), the patient's Physician of Record (or designee) must write an appropriate entry in the patient's Progress Notes. Such documentation should include the following information (at a minimum):
  - a. Description of the patient's diagnosis and prognosis;
  - b. Explanation of the grounds upon which the order is based;
  - c. Indication of the patient's decision-making capacity;
  - d. Description of conversation(s) between the Physician of Record (or designee) and the patient, or the patient's legal representative or surrogate (if the patient lacks capacity to make an informed decision), regarding the patient's preferences in relation to resuscitative efforts;
  - e. The names of other individuals who participated in the patient's code status decision-making and the basis upon which they were involved;
  - f. If applicable, reference to the physician of record's efforts to advise the patient or, when indicated, the patient's legal representative or surrogate, regarding the medical inappropriateness of resuscitation attempts, and hence medical appropriateness of an LCPR or DNAR order;
  - g. The general scope of the ensuing treatment plan, including specific instructions regarding limitation, continuation, and/or discontinuation of other forms of treatment (corresponding orders should be written as applicable) (note: an LCPR or DNAR order does not authorize the withdrawal of treatments that have been previously initiated).
2. Professional opinions, evaluations, and comments of any consultant who has reviewed the patient's medical condition and who is referenced in the Physician of Record (or designee)'s Progress Note must be part of the patient's medical record.
3. Copies of any advance directives (e.g., Living Will, Power of Attorney for Healthcare, Advance Healthcare Directive) or other evidence of a patient's preferences related to resuscitative measures (including a POLST form) which are referenced must also be included in the patient's medical record.
4. Healthcare team members who obtain information not already reflected in the medical record concerning the patient's Code Status preferences should appropriately document this

information and communicate this information to the Physician of Record (or designee).

*E. Time Limits*

A LCPR or DNAR Order remains in effect until there is a specific notation to change the status or when the patient is transferred to another level of care. If a LCPR or DNAR Order is to be continued, the physician must rewrite the Order on the physician's order sheet.

*F. When there is Conflict or Concern regarding Code Status*

In the event of disagreement or uncertainty regarding the appropriate Code Status for a patient, additional consultations and discussions are encouraged; the assistance of the Clinical Ethics Consultative Service is appropriate. If disagreement persists and cannot be resolved through the usual channels, however, Risk Management should be notified. In addition, the Physician of Record (or designee) may elect to recommend transfer of the patient to a physician who is willing to comply with the patient's (or Legal Representative or Surrogate) preferences.

**V. RELATED POLICIES AND PROCEDURES**

- Withholding or Withdrawal of Life Sustaining Treatment
- Clinical Ethics Consultation
- Medically Inappropriate Treatment in End-of-Life Health Care
- Health Care Decisions
- Patient Identification/Patient Wristbands