UC San Diego Health

Policy Name and Number	**MCP 380.1, Do Not Attempt To Resuscitate**
Effective Date	**January 13, 2015**
Original Approved Date	**4/1/1992**
Revised Date(s)	**12/1/1994, 10/27/1998, 8/21/2001, 4/20/2004, 10/26/2004, 5/22/2007, 5/20/2010, 11/18/2010, 11/21/2013, 1/13/2015**

ABSTRACT:

This policy and procedure is designed to provide guidelines to follow in those circumstances where the appropriateness of a DNAR order must be considered. The health care professionals of the UC San Diego Health System (UCSDH) are dedicated to the provision of compassionate medical care that benefits patients and their families. They strive to cure patients of their illnesses when possible and to relieve pain and suffering always. A hospital policy for DNAR orders is necessary because there is a hospital policy that cardiopulmonary resuscitation (CPR) should always be performed in the event of a cardiac arrest unless a DNAR order has been written. However, resuscitation attempts are not appropriate in some cases, such as patients who are permanently unconscious, or are suffering with a terminal illness (if death is anticipated within a relatively short time) and should not be offered. The primary principles that should govern decisions to issue DNAR orders are self-determination, patient welfare, and the determination that such treatments are non-beneficial or potentially inappropriate.

RELATED POLICIES:

UCSDH MCP 301.8, "Patient Rights and Responsibilities"
UCSDH MCP 305.1, "Advance Directives"
UCSDH MCP 360.1, "Organ and Tissue Donation"
UCSDH MCP 381.1, "Limitation of Life-Sustaining Treatments"
UCSDH MCP 381.2, "POLST (Physicians Orders for Life Sustaining Treatment)"
UCSDH MCP 530.1, "Medical Ethics Consultation"
UCSDH MCP 531.1 "Non-Beneficial Treatment Conflict Resolution"
UCSDH MCP 803.1, "Code Blue -- Adult/Pediatric"
Bylaws, Rules and Regulations of UC San Diego Medical Staff, Appendix III-Patient Right

I. DEFINITIONS

A. Code Status Options:

1. FULL CODE - Denotes that in the event of a cardiopulmonary arrest, cardiopulmonary resuscitation would be initiated.

2. DNAR/FULL CARE - Denotes that in the event of a cardiopulmonary arrest, cardiopulmonary resuscitation would NOT be initiated.

   **This code status offers 2 drop-down choices:

   a. Intubation acceptable and

   b. Other comments for write in options.

3. This code status option is intended for patient who would not want cardiopulmonary resuscitation, but are still accepting other forms of aggressive treatment.

4. DNAR/COMFORT CARE - Denotes that in the event of a cardiopulmonary arrest, cardiopulmonary resuscitation would not be initiated

5. ORGAN SUPPORT - This code status option is exclusively for patients who have been pronounced brain dead, and are on organ support temporarily in anticipation of organ donation.

B. Non-Beneficial (*Futile) Treatment:*

   Non-Beneficial (Futile) Treatment: Any treatment that has no realistic chance of providing a benefit that the patient has the capacity to perceive and appreciate, such as merely preserving the physiological functions of a permanent unconscious patient, or has no realistic chance of achieving the medical goal of returning the patient to a level of health that permits survival outside the acute care setting of UCSDH

C. *Responsible Physician:* The attending physician who has primary responsibility for the patient's care, or the senior physician trainee caring for the patient under the instruction of the attending physician.

D. *Attending Physician:* The Attending Physician primarily responsible for the care of the patient.

E. Decisional Capacity

   The patient is considered to possess decision-making capacity if the patient:

   1. Understands the nature of the medical condition and its prognosis;

   2. Understands the treatments that are available (including no treatment) and the expected outcomes, including both potential benefits and harm;

   3. Is able to use the information to arrive at a reasoned decision;

   4. Is able to express that decision in an understandable manner;

   5. Communicates consistent wishes over time.

F. *Advance Directive:* A written instruction that specifies in advance the individual's wishes about health care should the individual becomes unable to make such decisions. Examples are an Individual Health Care Instruction, a Durable Power of Attorney for Health Care valid under prior law, a Declaration valid under the former Natural Death Act**,** or a living will. In an Advance Directive, a patient states choices for medical treatment and/or designates who should make treatment choices if the person creating the advance directive should lose decision-making capacity. (Advanced Health Care Directive-Form 151-046)

G. *Natural Death Act Declaration:* A document in which the patient directs the physician to withhold or withdraw life-sustaining treatment in instances of terminal illness or permanent unconsciousness. Although the law creating the Natural Death Act has been repealed, declarations that were executed before July 1, 2000 remain valid if signed in conformance with the prior law.

H. *Durable Power of Attorney for Health Care (DPAHC*): A DPAHC is a type of advance directive that may be set up under the Health Care Decisions Law (CA Probate Code Sections 4600 et. seq.) by which an individual may name someone else (an "agent") to make health care decisions in the event that an individual becomes unable to make such decisions for himself or herself. A DPAHC based upon prior law is still valid if signed after July 1, 2000 only if it is executed on a pre-printed form. Under the Health Care Decisions Law, an individual may also include specific instructions regarding which health care treatment(s) should be utilized or omitted in the event of incapacity. The instructions given, if any, are to be followed by the agent. A Power of Attorney may not authorize the attorney In Fact to consent to any of the following on behalf of the principal:

1. Commitment to or placement in a mental health treatment facility;
2. Convulsive treatment (defined in Sec. 5325 of the W&I Code);
3. Psychosurgery (as defined in Sec. 5325 of the W&I Code);
4. Sterilization;
5. Abortion.

I. *Surrogate decision-maker:* An individual who participates in health care decision-making on behalf of an incapacitated patient. The surrogate decision-maker may be formally appointed (e.g., by a patient completing a DPAHC, by a patient who orally communicates such an appointment to their attending physician, or by a court in a conservatorship proceeding). In the event that a surrogate is designated orally by the patient, such information is to be promptly recorded in the patient's health care record. Such oral designations are valid only for the duration of the treatment, illness, or stay in the health care institution at which the designation was made. A patient may also exclude particular persons from being designated as surrogates by communicating their wishes in writing or to the supervising health care provider orally. This information is also to be included in the patient's record. In the absence of a formal appointment, a

surrogate may be recognized by virtue of relationship with the patient (e.g., the patient's next of kin or close friend). In the event that the patient has executed a Health Care Instruction, such instructions are to be followed by the surrogate. A surrogate decision maker may be provided with information about Advance Directives when an adult individual is incapacitated at the time of admission (due to an incapacitating condition or mental disorder). If the individual regains capacity, he/she must be provided with information regarding Advance Directives. A surrogate decision maker may not fill out an Advance Directive on behalf of an incompetent individual.

J. Minor Patients: Minors are usually considered legally incompetent to make decisions by virtue of their age. However, many minors will be able to understand the nature and consequences of a DNAR order. The Responsible Physician should discuss the implications of a DNAR order with the minor and his/her parents or guardians. A DNAR order should not be initiated unless the minor and the parent(s) or guardian(s) agree. If a conflict exists, the Responsible Physician should consult the Medical Ethics Consultation Team and Legal Counsel, as necessary.

K. Physician Orders for Life Sustaining Treatment (POLST): A document completed with the approval of the patient or surrogate and physician that addresses issues such as code status, preferred intensity of treatment and artificial nutrition/hydration. This document has the force of a physician's medical order and must be honored in all settings of care in California. The POLST remains with the patient wherever they receive care. (POLST-Form D626)

II. POLICY

It is the policy of UCSDH to respect the rights of patients or their surrogate decision makers, in conjunction with their treating physicians, to refuse cardiopulmonary resuscitation. This decision has no effect on any other therapy undertaken for the relief of suffering, nor does it limit care such as nutritional support, or antibiotics.

In instances where the patient has a Physician Orders for Life-Sustaining Treatment document, the wishes of the patient expressed in the POLST must be honored by law, except in a case where the patient's wishes are for non-beneficial or futile treatment(s).

There are two categories of patients in whom CPR is generally determined to be inappropriate:

A. A patient who is already on maximal life support in the ICU, and death is imminent (a patient who is actively dying). In these cases, resuscitation should not be offered or attempted. If the patent or surrogate(s) disagree, the conflict resolution process should proceed, per MCP 531.1, but the "DNAR" order may remain in effect. All cases should be reviewed retroactively by the Ethics Committee.

B. Patients in whom resuscitation may be effective, but not ultimately beneficial. Patients who are permanently unconscious or unaware, and will never be able to appreciate any benefit from continued life sustaining treatments (per our definition of non-beneficial treatment). The inappropriateness of CPR should be explained to the patient or surrogate, and they should be informed of the DNAR order. If the patient or surrogate

disagrees with this decision, the conflict should be addressed according to the policies and procedures in MCP 531.1. In these cases, the Full Code status should remain in place until the Conflict Resolution process is completed.

All inpatients will be considered a full code unless otherwise ordered. All resuscitation status orders for DNAR must be signed or countersigned by an Attending Physician.

The orders for resuscitation status are visible in the electronic medical record (EMR) for reference by the patient care team.

III. PROCEDURES AND RESPONSIBILITIES

A. Before writing the DNAR order, the Responsible Physician will discuss the DNAR order with the patient, or surrogate decision-maker. The Attending Physician should be involved in these discussions, if available.

B. Once the DNAR decision has been made, the order shall be entered in the EMR. Telephone or verbal DNAR orders will not be accepted. In those cases where the DNAR order must be entered without the Attending Physician physically present, a fellow or resident, **after discussing and obtaining approval from the Attending Physician**, may enter the DNAR order. The DNAR order must be countersigned by the Attending Physician within twenty-four (24) hours. It is the responsibility of the Attending Physician to ensure that this order and its meaning are discussed with all the physicians and nurses caring for the patient.

1. A DNAR Physician's Order must be timed and dated. Orders entered in the EMR will be timed and dated automatically.

2. Advanced Directives or POLST Forms, when available, will be scanned into the EMR.

3. If a patient at the time of admission presents with a POLST document designating DNAR status, this order should be included in the admitting orders.

4. The Progress Note should contain the:

    a. Circumstances and medical reasons for the DNAR order;

    b. Diagnosis and prognosis that supports any Attending Physician's determination of futility described under Section II above;

    c. Decisions and recommendations of the treatment team and consultants;

    d. The patient or surrogate's wishes and documentation of the discussion with the patient or surrogate regarding the decision to make the patient DNAR;

    e. Nature of the relationship between any surrogate decision maker and the patient.

C. The DNAR order should be under regular periodic review by the Attending Physician to ensure that the order remains current and consistent with the patient's desires, best interests, medical condition and prognosis.

1. The DNAR order shall be written in the EMR at the time of each readmission and accompanied by an appropriate Progress Note.

2. The circumstances justifying a DNAR order should be re-evaluated as the patient's clinical situation changes (for example, when a patient is transferred from one nursing unit to another, from one service to another, or from one level of care to another). The results of any re-evaluation should be documented appropriately in Progress Notes.

3. Attending Physicians assuming the care of patients with DNAR orders will continue those orders or will document why they should change. The Attending Physician shall be responsible for entering or countersigning within 24 hours any new resuscitation status orders within the EMR.

D. If a patient is admitted for surgery, interventional, or palliative procedures, with a DNAR order in effect, a physician who will be performing the procedure/surgery or the anesthesiologist will check off and initial the Surgical Consent Form section on DNAR Orders to indicate either that: (a) the DNAR order will be honored during the procedure and PACU period OR (b) that the patient/legal representative has been informed that the DNAR order will be suspended during the procedure and PACU period.

E. Physicians and health care professionals who feel that they cannot carry out a DNAR order may request a change of assignment provided such a change does not result in abandonment of the patient.

IV. ATTACHMENTS

None.

V. FORMS

Form D626: Physician Orders for Life-Sustaining Treatment (POLST)

Form 151-046: Advance Health Care Directive

VI. RESOURCES

None.

VII. REGULATORY REFERENCES

-- Health Care Decisions Law

-- California Code of Regulations, Title 22, Licensing and Certification of Health Facilities and Referral Agencies, Section 70707.

-- California Health and Safety Code, Sections 7180-7183: Brain Death, Uniform Determination Act; Sections 7185-7195: California Natural Death Act.
-- California Civil Code, 2410-2444: Durable Power of Attorney for Health Care.
-- Public Law 101-508: Patient Self Determination Act.
-- The 1995 Accreditation Manual for Hospitals: Patient Rights and Organizational Ethics.
-- California Association of Hospitals and Health Systems, Chapter 2 and Chapter 4, Withholding or Withdrawing Life-Sustaining Treatment.
-- Physician Orders for Life Sustaining Treatment - AB 3000 Chapter 266 Statutes 2008

VIII. APPROVALS

This policy and procedure was approved by the following committee(s):

Committee Name:	Date Approved:
Code Blue Committee	October 7, 2014
Ethics Committee	October 27, 2014
Critical Care Committee	November 7, 2014
Nurse Executive Council	November 21, 2014
Medical Staff Executive Committee	December 18, 2014
Health System Executive Governing Body	January 13, 2015