County of Los Angeles **Department of Health Services**

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 205
VERSION: 3

SUBJECT/TITLE: DO NOT RESUSCITATE ORDERS

PURPOSE: To specify the conditions under which Do Not Resuscitate Orders (hereafter referred to as "DNR") may be written, and the specifications of writing such orders.

DEPARTMENT: ALL

DEFINITION: POLST: Physician's Order of Life Sustaining Treatment

POLICY:

1. Cardio-Pulmonary Resuscitation (CPR) is unique among therapeutic modalities in that it is initiated by non-physician staff without a physician's order when cardiac or respiratory arrest is recognized. A specific instruction is necessary if CPR is not to be initiated (by anyone).

2. The term DNR refers to the suspension of the otherwise automatic initiation of CPR.

3. A DNR order will be considered when at least one of the following circumstances prevail:

    a. When there is an underlying incurable medical condition, when death is expected, imminent and inevitable, and when a patient's physician determines that CPR is not indicated should vital functions fail due to the natural course of the patient's illness.
    b. When a competent, knowledgeable patient has clearly expressed the desire that no CPR procedures be instituted in specified circumstances. A diagnosis of terminal illness is not required.
    c. When the patient has executed an advance directive or authorized his/her physician to write a POLST (Physician Order for Life Sustaining Treatment) order which states that under the current medical conditions, the patient wishes to allow a natural death and does not want resuscitative measures to be undertaken.

4. Discussion of DNR status with the patient (or representative) shall be the responsibility of the patient's primary care team. However, any provider involved in the care of the patient may initiate the DNR discussion with the consent of the patient and the primary care team.

5. Before the DNR order is written the patient (if competent) shall be consulted. No discussion shall be held with the family members/friends of a competent patient without the patient's consent. If the patient is a minor or has otherwise been declared incompetent, the patient's legal guardian, surrogate decision maker, or Durable Power Of Attorney (DPOA)/conservator shall be consulted. In the absence of a conservatorship or advance directive, next-of- kin or close friend of such a patient who is familiar with the patient's prior wishes can serve as the patient's surrogate decision maker. (When there is disagreement among the family members about what the patient's wishes would be, the Bioethics Committee should be consulted. Life should be supported until the disagreement is resolved.) See under special circumstances for patients without surrogates.

6. In all cases, the patient's desires, if known, take priority even if family members disagree with the patient's wishes. However, every attempt should be made to obtain a consensus between the patient and the family. The Bioethics Committee may be of assistance in exploring the ethical/interpersonal issues involved, and helping the involved parties reach a consensus.

7. When discussing DNR status, the health care providers should ensure that the patient (or representative) has sufficient information on which to make an informed decision. Thus, at a minimum, the discussion should include diagnosis, prognosis, and expected outcome of any resuscitative measures that might be undertaken. The fact that comfort and supportive measures will be continued must be made clear to the involved persons.

8. When discussing DNR status it should be emphasized to the patient or advocate that this is not a decision in which there is a right or wrong action. All parties are concerned with arriving at an outcome which is in the best interest of the patient.

9. The Los Angeles County Public Guardian has directed that DNR orders may not be issued for patients who are ward or conservatees of the Pubic Guardian. Where DNR orders may be indicated of such patients, the matter shall be discussed with the Public Guardian. The Office of the Public Guardian may be reached at (213) 974-0511 (during work hours) or (213) 974-1234 (evenings, weekends and holidays). The FAX is (213) 620-1405.

<u>Meaning of a DNR Order</u>

1. A DNR order is NOT an order to cease medical care, and this must be emphasized to the patient, family and all medical providers caring for the

patient. The patient should continue to receive all medical care given prior to writing the DNR, with the exception of any exclusions stated in the Advanced Directive or POLST. EVERY necessary measure will be taken to relieve the patient's pain and suffering and to maintain the patient's comfort.

2. A DNR/POLST order is always reversible upon request by the patient (if competent), surrogate decision maker, or conservator who signed the POLST order.

3. At Olive View-UCLA Medical Center, unless otherwise specified, a DNR order means:

    a. No chest compression
    b. No electrical cardioversion
    c. No intubation
    d. No automatic institution of ACLS drug therapy protocols
    e. No cessation of any ongoing therapy without a specific order unless stated in the Advance Directive or POLST order.

<u>Specifics of Writing the DNR Order</u>

Once the decision is made that a DNR order is appropriate, a physician above the level of Intern (PGY-1) may write a DNR/DNI order on the Physician's Order form. DNR/DNI orders written by physicians who are not Attendings (defined as one who has been granted either admitting privileges or consultative privileges by the PSA) require confirmation in the form of a confirmatory order or co-signature by an Attending physician. Non-Attending DNR/DNI orders will be valid up to 24 hours if accompanied by documentation that code status was discussed with an Attending. The DNR Discussion Note must be documented in the electronic health record.

1. The circumstances surrounding the DNR order will be documented in the the DNR Discussion Note in Clinical Workstation Documentation must include, but not be limited to:

    a. A summary of the medical situation
    b. The outcome of formal and informal consultation, if any, with other physicians and/or health care providers
    c. A statement summarizing the outcome of consultation with the patient (or representative) and a listing of other involved parties (whether or not they agree with the decision).

2. No renewal is required during a single admission.

3. The daily progress note must have an indication that the patient is DNR.

4. A POLST form may be completed in place of a DNR order but not required during the hospitalization. A licensed physician who is providing care for the patient may complete the POLST form with attending approval. The physician signing the POLST must also document this decision in Clinical Workstation under POLST note.

5. CPR will be automatically initiated by non-physician staff if there is no written and signed DNR order on the Doctor's Order Sheet or signed POLST document stating DNR.

6. Physicians responding to a situation where CPR was initiated because the patient was not DNR are obliged to assess the situation and decide whether or not continued resuscitative measures are appropriate. Futile care need not be provided, even if the patient was not DNR.

7. For any problems or questions, including resolving conflicts in decision making, a member of the Bioethics Committee shall be contacted.

Special Circumstances

1. For problems/dilemmas involving minors (children) the Bioethics Committee shall be contacted.

2. Conflict of views between patients and attendings: No Physician is required to provide what they believe to be futile care. However, at times there may be a conflict of beliefs which may occur between the Attending/Patient/Family as to what constitutes futile care. In such cases the Attending has the option to contact the Bioethics Committee. Results of that consultation are to be documented in the Progress Notes.

a. The Bioethics Committee shall be contacted, and a representative shall obtain the following information:

The medical facts of the case.

Ability of the patient to give any input about his/her wishes. If the patient is able to communicate, even if he/she is felt to lack decision-making capacity, the patient's wishes should be elicited. He/she may still have valuable input.

Presence of any potential conflict of interest with any parties involved in the decision-making process. Such conflict can be

financial, legal, personal, or undisclosed.

Views of any family/friends. It is very important that the committee diligently search for any evidence of what the patient's wishes would have been. This should include what the patient's religious/moral outlook was, and how this might have impacted the patient's decision-making process under ideal conditions.

b. The Bioethics Committee shall discuss all of the above information. Factors to be considered should be:

What the patient's (not the family's) wishes would have been given the medical situation. In order of priority, patients' previously stated wishes should be regarded highest, followed by family's/friends' perceptions of what the patient's wishes might have been, then what a reasonable person in a similar situation and with a similar value structure might do.

It should be noted that what the family members want is only relevant in so far as it may reflect the patient's value system. If it does not, then these wishes do not take precedence.

What the benefit and burden to the patient are of continuing the current treatment course.

Factors that should **not** be considered include the economic impact of the decision, the perceived social worth of the patient, or threats of litigation by outside parties.

3. Outpatient DNRs: The outpatient setting is a unique situation where special needs and considerations must be addressed. Every effort should be made in completion of the POLST order in the outpatient setting. A patient can be made DNR in the outpatient setting. To do so:

a. The licensed physician who is providing primary care for the patient shall complete the POLST form. The physician signing the POLST must document this decision in Clinical Workstation under POLST note and the outpatient progress note. The patient is to be given the pink copy of the form, and instructed to carry this with them. Family members should be notified of where the patient has placed the form. A copy made and placed in the consent section of the medical record and a copy of the form is given to the patient's designated surrogate decision maker.

b. The POLST order is valid across all care settings including home, long term care facilities, outpatient clinics, emergency room, subacute and inpatient setting as well during transfer by ambulance.

c. DNR is **not** a requirement for **Hospice referral.**

d. The DEM shall honor all valid outpatient DNR forms and POLST order forms, not just the ones specific to OVMC-UCLA Medical Center.

4. DNR in the Department of Emergency Medicine: When appropriate, the DEM may initiate a DNR order on a patient, following the protocol above in the main body of this policy. The attending DEM physician must write the order, and provide the documentation for the decision making. The DNR order is valid until the inpatient attending physician who will be assuming primary responsibility for the patient has seen/evaluated the patient. The inpatient attending must document concurrence with the DNR in the admission note.

5. DNR Orders in the operating room/during procedures: It is recognized that the circumstances surrounding surgery/anesthesia administration are unique, in that a patient may have an iatrogenic situation that is potentially reversible by CPR/ACLS protocols. This fact may make some physicians/health care providers uncomfortable about having a DNR patient undergo a procedure. However, this concern is superceded by the patient's right to make decisions about their own medical care. Furthermore, the fact that a patient is DNR **does not** exclude him/her from being a candidate for surgical procedures, especially if the procedure will alleviate suffering.

   Thus, when a patient who is DNR needs a surgical procedure, the following should be discussed and documented in the chart.

   a. The unique situation of undergoing a surgical procedure should be explained to the patient or surrogate. The fact that anesthesia and surgery have isolated risks which can be reversed with ACLS therapy should be discussed. The patient should then be asked what he/she wishes to do.

   b. The discussion and the patient's desires should be documented in writing in the Progress Notes by the Chief Resident or Attending Surgeon.

   c. The patient may elect to remain DNR, under all circumstances. This

means that if the patient were to have a cardiopulmonary arrest due to circumstances surrounding the procedure, they would still wish not to be resuscitated. This decision must be honored. If a health care provider feels uncomfortable performing a procedure on a patient under these conditions, then alternative arrangements must be made to ensure that the patient gets the appropriate care.

d. The patient may elect to have the DNR put on hold while in surgery/recovery.

e. The patient should not be coerced into reversing the DNR.

6. DNR Orders in Patients Without Surrogates

a. All patients are entitled to have appropriate medical decisions made on their behalf if they are unable to make those decisions. These decisions include deciding about initiating and withdrawing any treatment modalities, including supportive measures. The patient's rights should not be terminated because the treatment decisions involved life support.

b. A patient's rights regarding health care decisions are not terminated because the patient has no surrogate, or if the designated surrogate is unable to act in the patient's best interest. It may not always be in the patient's best interest to continue life sustaining or interventional measures, and such measure may be causing a patient undue suffering.

c. Decision-making capacity is defined as the ability to make a choice about various options for medical care, and to be able to understand the consequences of that decision. A ventilator patient should not be assumed to lack decision-making capacity. The presence of pain medication does not in and of itself exclude patients from participating in decisions about their care. Similarly, patients with psychiatric diagnoses have rights to participate in decisions about their care, as do demented patients. However, the latter two groups should be treated as having limited decision-making capacity.

d. A surrogate decision maker can be either:

1) a person previously designated by the patient as the individual they wish to make decisions for them, or:

2) a next-of kin or close friend who is aware of the patient's wishes

(either general or specific) regarding life sustaining treatments, and who does not have a conflict of interest in the decision making process, or:

3) a court-appointed individual.

e. If an attending physician decides that life-sustaining treatment should be withdrawn or not initiated for a patient who has neither full decision-making capacity nor a surrogate, then the following procedure should be followed. (If the surrogate is felt to have a conflict of interest, or does not appear to be acting in the patient's best interest or according to previously stated beliefs then the following shall also be enacted.)

1) The Bioethics Committee shall be contacted, and a representative shall obtain the following information:

The medical facts of the case.

Ability of the patient to give any input about his/her wishes. If the patient is able to communicate, even if he/she is felt to lack decision-making capacity, the patient's wishes should be elicited. He/she may still have valuable input.

Presence of any potential conflict of interest with any parties involved in the decision-making process. Such conflict can be financial, legal, personal, or undisclosed.

Views of any family/friends. It is very important that the committee diligently search for any evidence of what the patient's wishes would have been. This should include what the patient's religious/moral outlook was, and how this might have impacted the patient's decision-making process under ideal conditions.

2) The Bioethics Committee shall discuss all of the above information. Factors to be considered should be:

What the patient's (not the family's) wishes would have been given the medical situation. In order of priority, patients' previously stated wishes should be regarded highest, followed by family's/friends' perceptions of what the patient's wishes might have been, then what a reasonable person in a similar situation and with a similar value structure might do.

It should be noted that what the family members want is only relevant in so far as it may reflect the patient's value system. If it does not, then these wishes do not take precedence.

What the benefit and burden to the patient are of continuing the current treatment course.

Factors that should **not** be considered include the economic impact of the decision, the perceived social worth of the patient, or threats of litigation by outside parties.

After reviewing all relevant information, the committee will make a recommendation to the primary attending physician about DNR status of the patient. If the primary team disagrees with the committees' recommendations than a discussion shall be held with the Medical Director, Attending, and Chair of the Bioethics Committee.

7. Provider disagreement with DNR Orders

A healthcare provider is not obligated to participate in care that he/she finds morally offensive. At times, this can include non-initiation/removal of life support. If any healthcare providers find that they are unable to participate in an appropriate DNR order, then they should make arrangements to appropriately remove themselves from the care of the patient. Bioethics Committee consultation can be obtained for guidance.

References: California Consent Manual 2010, Appendix 2-D; Model Policy; Health Care Decisions for Unrepresented Patients.	
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