WEST VIRGINIA UNIVERSITY HOSPITALS *and Ambulatory Services* *POLICY AND PROCEDURE MANUAL*	**Policy IV.055** **1st Effective 8-1-89** **Revised 1-25-93; 2-23-93; 4-5-94; 8-21-98; 11-26-99; 6-19-00; 6-20-02; 7-25-02, 10-3-02; 4-11-08; 6-24-08; 2-18-11; 3-29-12; 5-20-16** **Reviewed 4-4-05**

NO CARDIOPULMONARY RESUSCITATION

POLICY

A. Statement of General Principles

The primary principles that govern decisions to issue no cardiopulmonary resuscitation (NO CPR) orders are patient self-determination and patient welfare. All patients with decision-making capacity have the right to make healthcare decisions, including the right to refuse cardiopulmonary resuscitation, as well as the right to complete advance directives. Patients who lack decision-making capacity have the right to have healthcare decisions made for them by their medical power of attorney representatives or surrogates. In many circumstances, the performance of cardiopulmonary resuscitation may offer no reasonable chance of medical benefit, and it may cause unwanted and unnecessary pain and suffering. In such cases, withholding of cardiopulmonary resuscitation is supported by the principles of nonmaleficence and beneficence.

B. Statement of Rationale

The healthcare professionals of West Virginia University Hospitals are dedicated to the provision of compassionate medical care that benefits patients. They strive to cure patients of their illnesses when possible and to relieve pain and suffering always. A hospital policy for NO CPR orders is necessary for two reasons: first, there is a hospital policy that cardiopulmonary resuscitation (CPR) should always be performed in the event of a cardiac or respiratory arrest unless a NO CPR order has been written; and second, the performance of CPR may not be wanted by or benefit all patients. For example, resuscitation may not be wanted by or benefit patients suffering with terminal illnesses (death is anticipated within six months) or debilitating irreversible conditions.

DEFINITIONS

A. Attending Physician

The attending physician is the licensed physician selected by or assigned to the patient who has primary responsibility for treatment or care of the patient. If more than one physician shares that responsibility, any of those physicians may act as the attending physician.

B. NO CPR

NO CPR means that, in the event of persistent bradycardia in a neonate or an acute cardiac or respiratory arrest in a patient of any age, no intubation, defibrillation, chest compressions or cardiac drugs are to be initiated.

C. Respiratory Arrest – Means total cessation of breathing.

D. Cardiac Arrest – means cessation of pulse due to asystole, pulseless electrical activity, or ventricular fibrillation.

E. Incapacity

Incapacity or words of similar import means the inability because of physical or mental impairment to appreciate the nature and implications of a healthcare decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner

PROCEDURE

A. Issuance of NO CPR Orders

1. For patients with terminal or debilitating irreversible illnesses at risk of cardiac or respiratory arrest, the attending physician and the fellow or resident physician primarily involved in a patient's treatment, or either thereof, are responsible for initiating a discussion with the patient regarding resuscitation. This discussion should be held with the patient, if he or she has decision-making capacity, or with the patient's medical power of attorney representative or surrogate, if he or she lacks decision-making capacity. *See* Policy No. III.010, Informed Healthcare Decision-Making by Patients or Surrogates.

(a) Patients with Decision-making Capacity

(i) A patient with decision-making capacity has the right to request or refuse treatment and to formulate advance directives and to have the hospital staff and practitioners comply with his or her directives. A patient does not, however, have the right to treatment or services deemed medically unnecessary or inappropriate.

(ii) A patient with decision-making capacity has the right to request that CPR not be initiated and that his or her physicians issue a NO CPR order. The patient also has the right to request that a NO CPR order be rescinded. If the patient and physician cannot agree on resuscitation status, the physician has the options listed in Subparagraph A(1)(a)(iv), below.

(iii) As soon as a treating physician determines that a patient with decision-making capacity does not want to undergo CPR, the physician shall enter a No CPR order. A licensed physician is responsible for issuing the NO CPR order.

(iv) If the physician judges that a NO CPR order is appropriate because there are no expected benefits of CPR, or the expected benefits are outweighed by the expected harms to the patient, the physician shall recommend a NO CPR order to the patient. A NO CPR order shall be written if the patient accepts the physician's recommendation and consents to the order. If the patient does not accept the physician's recommendation and consent to a NO CPR order, the physician should proceed as follows:

a. The physician may seek a second opinion;

b. The physician may consult the WVUH Ethics Committee;

c. The physician may seek a transfer of the patient to another physician or institution; or

d. If a transfer is not feasible and if, after consultation with another physician or the WVUH Ethics Committee, or both, the physician believes that resuscitation is contrary to the standards of accepted

medical practice, but the patient still does not accept the physician's recommendation, the physician may write a NO CPR order after notification to the patient. The physician contemplating this action may wish to consult with the WVUH Ethics Committee if he or she has not already done so or, if appropriate, the Robert C. Byrd Health Sciences Office of Risk Management.

(v) If a patient expresses the desire not to be resuscitated to other members of the healthcare team, *e.g.*, a nurse, social worker or students, this information should be communicated to the attending physician as soon as possible. The attending physician remains responsible for the No CPR order.

(b) Patients with Incapacity

(i) When a patient is incapacitated and has previously executed a living will and the living will is in effect because the patient is in a persistent vegetative state or terminally ill, the wishes of the patient expressed in the living will, including forgoing CPR and having a NO CPR order written, shall be respected by the attending physician and all other members of the healthcare team. When a patient is incapacitated and has previously completed a medical power of attorney that specifies a representative, the attending physician is responsible for initiating a discussion of resuscitation measures with the representative. NO CPR decisions will be made by the representative and the attending physician. A NO CPR order may be written when the representative consents because the patient would not have wanted CPR in the present circumstances or the representative and physician agree that CPR would not be in the patient's best interests, or both.

(ii) When a patient who is incapacitated has not designated a medical power of attorney representative, the attending physician is responsible for selecting a surrogate decision-maker and initiating a discussion of resuscitation measures with the surrogate. NO CPR decisions will be made by the surrogate and the attending physician. A NO CPR order may be written when the surrogate consents because the patient would not have wanted CPR in the present circumstances or the surrogate and the physician agree that CPR would not be in the patient's best interests, or both. (*See* Policy No. III.010, Informed Healthcare Decision-Making by Patients or Surrogates.)

(iii) If the attending physician judges that a NO CPR order is appropriate because there are no expected benefits of CPR, or the expected benefits are outweighed by the expected harms, the physician may recommend a NO CPR order to the medical power of attorney representative or surrogate decision-maker. If the representative or surrogate does not accept the physician's recommendation and refuses to consent to a NO CPR order, the physician should proceed as follows:

a. The physician may seek a second opinion;

b. The physician may consult the WVUH Ethics Committee;

c. The physician may seek a transfer of the patient to another physician or institution; or

d. If a transfer is not feasible and if, after consultation with another physician or the WVUH Ethics Committee, or both, the physician believes that resuscitation is contrary to the standards of accepted medical practice, but the representative or surrogate still does not

accept the physician's recommendation, the physician may write a NO CPR order after notification to the medical power of attorney representative or surrogate. Since this action, while medically and ethically correct, may place the physician at risk of litigation, the physician contemplating this action may wish to consult with the WVUH Ethics Committee if he or she has not already done so or, if appropriate, the Robert C. Byrd Health Sciences Office of Risk Management.

(iv) If a surrogate decision-maker is not reasonably available or capable of making a decision regarding a NO CPR order, the attending physician may issue a NO CPR order for an incapacitated hospital patient, provided that a second physician who has personally examined the patient concurs in the opinion of the attending physician that the provision of CPR would be contrary to accepted medical standards.

(c) NO CPR orders for minors

For a non-emancipated minor who is less than 16 years of age and who has not been determined to be mature for the purposes of medical decision making, the physician may issue a NO CPR order with the consent of a parent, provided that a second physician who has examined the minor concurs with the attending physician that the provision of CPR would be contrary to accepted medical standards. The options for a physician when a parent does not consent to a recommended NO CPR order are the same as those listed in Subparagraph A(1)(a)(iii), above. If the minor is between the ages of 16 and 18, and in the opinion of the attending physician the minor is of sufficient maturity to understand the nature and effect of a NO CPR order, then no such order shall be valid without the consent of such minor. If there is a conflict between the wishes of the mature minor and his or her parents or guardians, the wishes of the mature minor shall prevail. If agreement cannot be reached between two parents about resuscitation status or between a parent and the minor, consultation with the WVUH Ethics Committee is recommended.

2. If resuscitation status has not yet been established or discussed and the patient's illness is terminal and irreversibly debilitating, or either thereof, the primary nurse will discuss with the attending physician the appropriate plan of care. Under these circumstances, the attending physician or his/her designee should as soon as reasonably possible talk to the patient about preferences with regard to CPR.

3. When there are conflicts among the physician, other members of the healthcare team, the patient, and the patient's medical power of attorney representative or surrogate, the family, or any thereof, regarding the issuance or continuation of a NO CPR order, consultation with the WVUH Ethics Committee is encouraged.

4. The NO CPR order, if it remains appropriate, shall be reissued at the time of each admission.

5. In circumstances in which it is clear to the nurse performing the admission assessment that the patient or the patient’s medical power of attorney representative or health care surrogate (if the patient lacks decision-making capacity) does not want CPR, the nurse shall promptly inform the admitting resident. The admitting resident shall make it a priority to confirm the preference for No CPR with the patient or the patient’s medical power of attorney representative or health care surrogate, and enter the No CPR order. In the event that the No CPR order has yet to be entered and the patient is at imminent risk of experiencing a cardiac arrest or has undergone a cardiac arrest, the nurse shall respect the patient’s clear directive for No CPR and not call a code. The admitting resident shall be promptly informed of the patient’s status so that appropriate comfort measures can be instituted.

6. If the patient has a validly completed West Virginia Do Not Resuscitate (DNR) Card or a Physician Orders for Scope of Treatment (POST) form indicating Do Not Attempt Resuscitation but a No CPR has yet to be entered, then, provided there are no conflicting directives from the patient, the nursing staff shall respect the patient's wishes as expressed on the DNR card or the POST form and not initiate CPR in the event of cardiac arrest. The admitting resident shall be promptly informed of the patient's status so that appropriate comfort measures can be instituted.

B. Documentation of CPR Orders

1. All patients will receive a "CPR" sticker on their identification band upon arrival unless there is documentation of a "No CPR" order, "Limited Treatment" order, evidence of a DNR card or a DNR order in the Physician's Orders for Scope of Treatment (POST) form. In these cases, the patient will receive a "No CPR" or "Limited Treatment" sticker on their ID band, as appropriate.

2. When a NO CPR decision has been made during a hospitalization, this directive shall be entered as an order in the Electronic Medical Record (EMR) by the attending physician, resident, or mid-level provider on service. 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. The patient's nurse is responsible for taking the No CPR order from the Electronic Medical Record (EMR) and asking the unit clerk to make a new identification band on which a No CPR sticker is placed. The patient's nurse shall ensure that the No CPR sticker is present on the patient's identification band after a No CPR order has been entered.

3. When a patient is admitted to WVUH, physicians shall check in the Electronic Medical Record (EMR) under "Code History" accessed from Record Select under Patient Summary to see if a NO CPR order has been previously issued for the patient. If so, the physician shall confirm the No CPR order with the patient. In confirming the order with the patient, it is not necessary to conduct a full discussion of the benefits and risks of CPR unless the patient desires to have this discussion again. If the patient has not previously consented to a NO CPR order a discussion shall be held with the patient as described in section A of this policy and procedure. If the patient agrees to a NO CPR order, a NO CPR order shall be documented as in subsection 1 above of this section. 4. If a patient agrees to a NO CPR order and is subsequently discharged, the NO CPR order shall be documented in the hospital discharge summary after the discharge diagnosis section. The patient shall also be issued a West Virginia orange Do Not Resuscitate card and/or a Physician Orders for Scope of Treatment (POST) Form, See II. 056, section H, at the time of discharge.

C. Revocation of NO CPR Order

1. A change from No CPR to Full Code is appropriate if there has been a significant improvement in the patient's condition such that CPR is likely to be of benefit and only with the agreement of the attending physician.

2. At any time, a patient with decision-making capacity may express a desire to revoke his or her previous consent to a NO CPR order by communicating his or her revocation to a physician or other professional staff of the hospital; however, change in CPR status from No CPR to Full Code by an on call or covering resident is strongly discouraged since these decisions are best made by the team primarily responsible for the patient's care.

3. At any time, a medical power of attorney representative or surrogate may express a desire to revoke his or her consent to a NO CPR order for an incapacitated patient by notifying a physician or other professional staff of the hospital of the revocation in writing or by orally notifying the attending physician in the presence of a witness 18 years of age or older; however, change in CPR

status from No CPR to Full Code by an on call or covering resident is strongly discouraged since these decisions are best made by the team primarily responsible for the patient's care. .

4 The physician who is notified of the expressed desire to revoke consent to the NO CPR order is responsible for discussing the reasons for the revocation with the patient, Medical Power of Attorney representative or surrogate to ensure that the decision is an informed one.

If the decision is an informed one and appropriate based on the patient's medical condition, the attending physician shall immediately discontinue the NO CPR order, unless he or she believes discontinuation is contrary to accepted medical standards. If so, he or she may proceed as described in Subparagraphs A(1)(a)(iv) and A(1)(b)(iii), above.

5. An on call or covering resident should defer changes from No CPR to Full Code even if requested by the patient to discussion with the primary team the next morning. In the event of an emergency, the on call or covering resident should change the patient's order from No CPR to Full Code only after notifying the attending physician and obtaining the attending physician's approval.

6. In an emergency if the attending physician is not able to be contacted, a senior resident/licensed physician may make a change from No CPR to Full Code if and only if consistent with accepted medical standards.

7. Professional staff other than physicians who are notified by a patient Medical Power of Attorney representative or surrogate of a revocation of consent to a NO CPR order shall immediately notify the attending physician of such revocation.

8. Only a physician may discontinue a NO CPR order. The physician shall discontinue the NO CPR order inthe Electronic Medical Record (EMR) The patient's nurse is responsible for taking the order from the Electronic Medical Record (EMR) and asking the unit clerk to make a new identification band on which a CPR sticker is placed. The request of a patient with decision-making capacity to revoke a NO CPR order shall be respected if there is not time to obtain a physician's order to this effect prior to the patient's cardiopulmonary arrest.

9. A physician who discontinues a NO CPR order shall be responsible for informing other physicians, nurses and others involved in the patient's care of the revocation and discontinuation .

10. The nurse shall indicate the discontinuation of the NO CPR status at nursing report.

D. Periodic Review of the No CPR Order

1. The NO CPR order should be reviewed if the patient's prognosis changes or if new information becomes available about the patient's likelihood of benefit from CPR by the attending physician (or his/her designee) and the patient to ensure that the order remains current and consistent with the patient's medical condition, prognosis and wishes.

2. Occasionally, patients with NO CPR orders undergo procedures inside and outside of the Operating Room with different levels of anesthesia from moderate sedation to general anesthesia. Because the administration of anesthesia is associated with cardiac and respiratory depression that may lead to a cardiac or respiratory arrest that usually is reversible, patients who have NO CPR orders may not necessarily want CPR withheld if the cardiac or respiratory arrest is precipitated by anesthesia. Therefore, it is necessary for a physician treating a patient who has a NO CPR order and who is to undergo anesthesia to discuss again the patient's resuscitation status and goals for treatment and the circumstances under which the patient would not want to be kept alive with life-sustaining treatments. If the patient is incapacitated, this discussion shall be held with the patient's medical power of attorney representative or surrogate decision-maker. The presumption is that the

NO CPR order will be suspended while the patient is under anesthesia and until the patient has recovered from anesthesia and the patient has returned to his or her pre-procedural room. Some patients may not agree to the temporary suspension of the NO CPR order, and further discussion between the patient and physician may be necessary to reach a decision about resuscitation status that is acceptable to all. Decisions made with regard to continuation or suspension of the No CPR status while the patient is undergoing a procedure and anesthesia should be documented in the patient's medical record. If an impasse is encountered, consultation with the WVUH Ethics Committee is encouraged. Separate considerations are necessary for patients undergoing anesthesia while on mechanical ventilation in the intensive care units. With the consent of the patient or the patient's Medical Power of Attorney representative or surrogate, such intensive care unit patients may have No CPR orders while receiving anesthesia.

E. Meaning of No CPR Order

A NO CPR order means only that healthcare professionals at WVUH facilities shall not attempt cardiopulmonary resuscitation on a patient for whom a NO CPR order has been issued. NO CPR orders are otherwise compatible with a range of therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for a NO CPR order. Consequently, an individualized plan of care should be formulated for the patient, reflecting the NO CPR order, and this plan should be explained to nurses and other members of the healthcare team.

F. Prohibition of Partial Codes

Orders for partial codes in the event of cardiopulmonary arrest, such as medications only are not appropriate. . This policy does not preclude the use of a limited treatment plan for other life-sustaining treatments. Please see "Treatment Limitations" under Order entry in the Electronic Medical Record (EMR) .

G. Compliance with No CPR Identification and Documentation

If a patient experiences cardiac or respiratory arrest in the Emergency Department or after admission to the hospital, healthcare professionals at WVUH shall not initiate CPR if the patient is wearing or carrying West Virginia DNR identification. Health Care Professionals at WVUH shall also comply with a Do Not Resuscitate order on a Physician Orders for Scope of Treatment (POST) Form.

H. Issuance of NO CPR Order Cards at Hospital Discharge

A physician discharging a patient who has had a NO CPR order while in the hospital should offer to complete and provide a DNR order card and/or a Physician Orders for Scope of Treatment (POST) Form as set forth in state law to such patient at the time of discharge.

I. Transfer of Patients with Orders to Other Healthcare Facilities

If a patient with a NO CPR order is to be transferred to another healthcare facility from WVUH, the fact that a NO CPR order is in effect for the patient shall be communicated to the receiving facility prior to transfer, and the written NO CPR order shall accompany the patient during the transfer.

J. Acceptance of Patients with NO CPR Orders from Other Healthcare Facilities

If a patient with a NO CPR order is transferred to WVUH, the NO CPR order accompanying the patient from the other facility shall remain in effect at WVUH until admission orders are written here. At such time, the admitting physician shall follow the procedure described in Paragraph A of this policy.

K. Refusal to Issue NO CPR Order

Any physician who refuses to issue a NO CPR order at a patient's request or to comply with a properly entered NO CPR order must take reasonable steps to promptly advise the patient or his or her Medical Power of Attorney representative or surrogate decision-maker that he or she is unwilling to effectuate the order. The attending physician shall thereafter at the election of the patient, representative or surrogate permit the patient, representative or surrogate to obtain another physician.

L. Relationship to Existing Hospital Policies

1. This policy is cumulative with other WVUH policies regarding life-threatening emergencies. Nothing in this policy is meant to abrogate consent procedures in emergency situations.

2. *See also* Policies No. III.025, Patient Advance Directives; and No. IV.056, Withholding and Withdrawing Life-Sustaining Treatment; No.IV.059 End of Life Care; and III.010 Informed Health Care Decision Making..

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