CASCADE VALLEY HOSPITAL AND CLINICS{PRIVATE }
POLICY & PROCEDURE

NUMBER: 03-3-045		DATE EFFECTIVE: 10/91	
TITLE: Do Not Resuscitate Orders	APPROVAL SIGNATURE:		
	REVIEW DATE	REVISE DATE	SIGNATURE
DIVISION: CVHC DEPARTMENT: Universal Patient Care	10/09	10/09	
ROUTE TO: Med Staff Serv, DPCS, All Nursing Units, Lab, Rad, Anes, OR	1/10	1/10	
	8/10		
CROSS REFERENCE:	11/13		
	6/14	6/14	

SCOPE This procedure applies to all employees and practitioners, of employment or Cascade Valley Hospital and Clinics.

PURPOSE The purpose of this policy is to establish procedures to be followed when decisions concerning Do Not Resuscitate ("DNR") are to be made. The hospital's philosophy is to provide dignity to impending death situations by adhering to the wishes of the patient and by instituting medically appropriate care. All patients are to be resuscitated, unless the physician writes or issues DNR order.

DEFINITIONS

A. DNR Order
An order whereby the patient will receive all medically appropriate therapeutic care, but cardiopulmonary resuscitation will not be initiated upon the patient's cardiac or respiratory arrest.
1. A “NO CODE” order cannot interfere with the normal care and comfort considerations for the patient in the surgical suite.

B. Do Not Resuscitate in the OR
T**he DNR designation requires reconsideration upon surgery or anesthesia.**
The patient and the physicians who will be responsible for the patient’s care should discuss the new risks and the approach to potential life-threatening problems during the perioperative period. The results of such discussions should be documented in the record and communicated to the members of the operating room team.

C. Decision-Capable Patient
A patient shall be considered to be decision-capable if the patient is:
1. A adult 18 years of age or older
2. A minor who is married, a parent, or emancipated
3. Conscious
4. Able to understand the nature and severity of the illness involved
5. Able to understand the possible consequences of alternatives to the proposed treatment
6. Able to make informed choices concerning the course of treatment

All six conditions must be met.

D. Decision-incapable Patient

A patient shall be considered to be decision-incapable if the patient is:

1. A minor under 18 years of age, unless the patient is a minor who is married, a parent, or emancipated
2. Is unable to understand the nature and severity of the illness involved
3. Is unable to understand the possible consequences of and alternatives to the proposed treatment
4. Is unable to make informed and deliberate choices concerning the course of treatment
5. Has been declared legally decision-incapable by a court

Any one of these conditions renders the patient decision incapable.

E. Patient Representative

If a patient is decision-incapable, treatment decisions may be made on behalf of the patient by one of the following individuals, if reasonably available, willing and decision-capable, in this order or priority:

1. A judicially appointed guardian, if any
2. A person or persons designated by the patient in writing to make the treatment decision for him, e.g. by a durable power of attorney
3. The patient's spouse
4. An adult child or the majority of the adult children who are available
5. The parents of the patient
6. The nearest living relative of the patient

The individual of the highest priority shall act as the decision-incapable patient's representative. If none of the individuals listed in 1. through 6. are available, willing or decision-capable, resuscitate the patient.

PROCEDURE

A. The physician must discuss ***the levels of resuscitation*** with the patient, explaining the basis for and the consequences of a ***resuscitation*** order. If the patient is decision-incapable, this discussion must be held with the patient representative and other available family members. All such discussions must be noted on the patient's medical record.

B. If the patient is decision-capable, then the patient must consent to ***an order for the level of resuscitation*** before the order can be written. If the patient is decision-incapable, then the patient representative must consent to the entry of the order before the order can be written. In either case, the attending physician must indicate on the patient's medical record that consent has been obtained and the procedure by which the consent was obtained. A level of ***resuscitation*** order may not be written or implemented without obtaining consent, and the physician shall specify one of the following code levels by designating the level in the physician's orders:

1. ***FULL CODE***
   All resuscitative efforts possible are made
2. ***CHEMICAL CODE***
   Medications will be given
   - ***a. No intubation***
   - ***b. No CPR***
   - ***c. No defibrillation or counter shock***
3. ***NO INTUBATION***
   No intubation, all other measures will be employed
4. ***DNR, NO CODE, OR COMFORT MEASURES ONLY***
   No attempt to intervene with potentially fatal dysrhythmias or cardiac/respiratory arrest.

C. Written documents, such as a Living Will or Advance Directive, which express a desire not to be kept alive by resuscitative or life-prolonging measures, shall be attached to the patient's medical records. These documents shall not be used as a substitute for obtaining consent from the patient or the decision-incapable patient's representative. However, they may be used in discussions with family members to determine patient's wishes when the patient is decision-incapable.
D. The order must be written, timed, dated and signed by the physician.
E. If there is disagreement among/between physicians caring for the patient, the order may neither be written nor implemented and the physicians shall notify the Chief of Staff and the Assistant Administrator - Care. Either or both of the above shall take such actions as are necessary to facilitate resolution of the matter. These actions may include but are not limited to:
    1. Directly reviewing and expediting resolution of the matter
    2. Referring the matter for review by an appropriate existing patient care advisory or ethics committee
    3. Forming an ad hoc committee to review the matter
F. If the patient's physician cannot, in good conscience, after following procedures 1. through 3, write a DNR order in compliance with the wishes of a decision-capable patient or the patient representative, or the physician feels the decision is not in the best interests of the patient, the physician may offer to transfer the patient to the care of another physician in this or another health care facility.
G. The DNR order must be reviewed upon significant change in the patient's condition.
H. Intravenous fluids and/or feeding by tube or other artificial means may be considered life-sustaining and, therefore, may be withheld or withdrawn. But, if there is no direction regarding artificially provided fluids and nutrition in a properly executed advance ||directive, these shall be provided. Use of the Palliative Care Order Set (POPC) can help ||in physician care decisions.

||This protocol will be reviewed every three years by the Medical Staff, Nursing and Pharmacy ||Departments to confirm its continuing efficacy and safety.

Attachment I

Form POPC (09/13)
Page 1 of 1

Cascade Valley Hospital - Arlington, WA 98223

Pain	**For pain out of control: (Select drug)** ☐ Morphine 15 mg concentrated liquid Q1hr as needed for pain. Bolus with narcotic until patient is comfortable (Pain scale of 3 or below) ☐ Morphine 0.05 mg/kg IV Q10min until comfortable ☐ Hydromorphone 0.01 mg/kg IV Q10min until comfortable ☐ Fentanyl 0.5 mcg/kg IV Q5min until comfortable Begin continuous narcotic infusion: ▪ Start at an hourly rate equal to 50% of total dose required above and bolus with 50% of hourly rate Q10min as needed ▪ Titrate infusion as needed based on patient's reported pain scale and use of boluses: a. Increase continuous rate and bolus dose for pain reported greater than or equal to 5 on pain scale b. Determine total dose via continuous and bolus doses and divide by the time frame evaluated. This is the new hourly rate c. New bolus dose is 50% of continuous rate.
Sedation	☐ Lorazepam 1 mg PO Q1hr PRN anxiety - may give PR if NPO and no IV access ☐ Lorazepam 0.5 - 2 mg IV Q1hr. PRN anxiety ☐ Lorazepam infusion 0.5 - 1 mg/hr initially, up to 5 mg/hr. If dosages greater than 5 mg/hr are needed call MD for orders ☐ Haloperidol 1 - 2 mg IV Q1hr **OR** ☐ 0.5 - 1 mg PO or PR Q1hr PRN agitation
Respiratory	**For increased respiratory secretions:** ☐ Scopolamine patch 1.5 mg topically Q72hrs ☐ Hyoscyamine 0.125 mg PO or SL Q4-6hrs PRN ☐ Atropine 1% drops 1 drop PO or SL Q2-4hrs PRN
GI	**For nausea/vomiting:** ☐ Metoclopramide 10 mg IV/PO Q4hrs PRN ☐ Ondansetron 4-8 mg IV/PO Q4hrs PRN ☐ Promethazine 12.5 mg IV **OR** ☐ 25 mg PO Q6hrs PRN ☐ Prochlorperazine 25 mg PR Q12hrs PRN **For constipation:** ☐ Initiate Bowel Care Protocol
Nursing	☐ Acetaminophen 650 mg PO/PR Q6hrs PRN fever ☐ Hospice referral ☐ Wound Care consult No routine vital signs Position changes and 02 for comfort or skin care Record pain scale in nursing notes Food/fluid as desired, no forcing Indwelling catheter PRN for comfort or skin breakdown Allow unlimited family/loved ones visitation

Physician Signature	Date	Time	Noted By	Date	Time

Palliative Care Orders