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Limitation of Resuscitation Documentation and Orders, 11647

Policy/Procedure

PURPOSE:

1. To allow for and encourage documentation of discussions regarding goals of medical care, limitation of resuscitation, and/or end of life decisions for each individual child and family.
2. To provide an easily accessible written record of these discussions in order to avoid unnecessary repetition of emotional and complex discussions for families.
3. To provide guidance to health care providers about the rationale and procedure for writing limitation of resuscitation orders.
4. To provide medical providers with a clear and explicit plan for resuscitation prior to a medical emergency.

Note: This policy refers to limitation of resuscitation rather than "Do Not Resuscitate" or "Do Not Attempt Resuscitation" to avoid the connotation of discontinuing care or commitment to our patients.

POLICY:

Cardiopulmonary resuscitation (CPR) is a potentially life saving, emergency intervention that should be initiated when cardiopulmonary function is physiologically inadequate to sustain life. However, there are circumstances where the burdens of these emergent resuscitation measures potentially outweigh the benefits within the context of the goals of care. Under these circumstances, providers and other care team members as directed by the attending, should review the goals of care with families, discuss the potential burdens and benefits of these emergent measures, and document these conversations in the Patient's medical record. Decisions regarding specific interventions should be provided within the limitation of resuscitation order set.

PROCEDURE:

I. **DEFINITIONS**

A. **Cardiopulmonary Resuscitation** (CPR): An attempt to restore cardiac and pulmonary function when cardiopulmonary function is physiologically inadequate to sustain life. Procedures may include

placement of an artificial airway, artificial respiration, chest compressions or cardiac massage, electrical cardioversion, and the administration of resuscitative medications. These efforts are implemented under the guidelines of the American Heart Association for different patient populations, including neonates (NRP), pediatric patients (PALS) and adults (ACLS).

B. **Limitation of Resuscitation Order**: An order to describe the emergent resuscitative interventions that should be provided when cardiopulmonary function is physiologically inadequate to sustain life. This order is compatible with maximal efforts, other than resuscitation or other identified life sustaining interventions, to treat the patient with therapeutic measures including, but not exclusive of, surgery, medicines, intensive care or other interventions aimed at palliation or cure. It is **not** a signal to abandon or ignore the patient; rather, it implies a previously identified and alternative supportive care plan.

C. **Code Status**: Descriptive term used to provide an overview of the goal-directed approach to providing emergent resuscitative measures when cardiopulmonary function is physiologically inadequate to sustain life. This term is posted on the Patient Summary Page in the electronic health records. Options include "Full Support, indicating that all resuscitative efforts should be performed and "Limited Support", indicating that specific resuscitative efforts or comfort care should be provided according to the goals of care. The Code Status of each Patient should be reviewed by all health care providers caring for the Patient.

D. **Patient/Parent(s)**: Throughout this document, the term "Parent(s)" refers to the Surrogate Decision Maker for the Patient when the Patient is a Minor or is incapacitated. Please refer to **Administrative P&P,** Legally Authorized Person for Informed Consent Decision Making, 10628 for full details. "Patient" acknowledges that Patients 18 years and older and Emancipated Minors are the legal decision maker, unless they are incapacitated. Patients 18 years and older may make decisions to limit resuscitation in conjunction with an Advance Directive or in isolation. Please see **Bioethics P&P,** Advance Directive, 10033 for more information. Furthermore, when the Patient is a Minor, considerations should be made to include the Patient, when developmentally and neurocognitively appropriate, in the decision making process.

II. PROCEDURE FOR DISCUSSING AND DETERMINING CODE STATUS (See Appendix II.)

A. **Establish goals of care:**
Under **all** circumstances of hospitalization, the provider team should facilitate a conversation with the Patient/Parent(s) to:

1. Ascertain the Patient/Parent(s) understanding of the disease process.
2. Review options for treatment, including the potential risks, benefits, and alternatives.
3. Elicit the values and preferences of the Patient/Parent(s).
4. Based on the recommendations of the Attending Physician and within the context of the values and preferences of the Patient/Parent(s), identify the **goals of medical care.**
These discussions are likely iterative and ongoing, as the goals of care evolve and change over time throughout the course of an illness.

B. **Review and documentation of Code Status:** Depending on the underlying disease process, potential therapies and treatments, preferences and values of the Patient/Parent(s), and goals of medical care, there are **two** circumstances in which providers should consider reviewing and discussing with Patient/Parent(s) the possibility of **limiting resuscitation**. In both of these circumstances, it is imperative to remember that unique personal, familial, religious, or cultural

factors may make attempting CPR unusually beneficial.

1. **Relative benefits and burdens of attempting CPR are uncertain (i.e. life limiting diseases that have not reached terminal stages):** Based on the goals of care as discussed with the Patient/Parent(s), prior experience, medical knowledge, and empirical data, the provider team may determine that attempting CPR is a **plausible option**, however there is a **great level of uncertainty in outcome**, and CPR **potentially** could be more burdensome than beneficial.
    a. The provider team should review the goals of care, discuss the potential benefits and burdens of attempting CPR, acknowledge the uncertainty in outcome with the Patient/Parent(s), and offer **CPR as a plausible option**.
    b. The provider team should assist, guide, and support the Patient/Parent(s) with the decision to either attempt or limit resuscitation depending on the goals and values of the Patient/Parent(s). Reasonable efforts should be made to effectively communicate information necessary to enable a reasoned evaluation and voluntary decision.
    c. The discussion should be documented and the limitation of resuscitation order should be completed by a provider according to the discussion. **See Section III**.
2. **Burdens of attempting CPR likely outweigh the benefits (i.e. life limiting diseases in the terminal stages):** Based on the goals of care as discussed with the Patient/Parent(s), prior experience, medical knowledge, and empirical data, the Attending Physician may determine that **the burdens of attempting CPR** likely **outweigh the benefits**.
    a. The provider team should review the goals of care and discuss with the Patient/Parent(s) that **the burdens of attempting CPR** likely **outweigh the benefits**. To prevent causing unnecessary harm to the patient, the provider team should recommend against **attempting CPR.**
    b. If the Patient/Parent(s) assent to limiting resuscitation, the discussion should be documented and a limitation of resuscitation order should be written. **See Section III**.
    c. If the Patient/Parent(s) do not assent to limiting resuscitation, the discussion should be documented and full or modified resuscitation orders should remain in place, according to the wishes and preferences of the Patient/Parent(s). **See Section III**.

III. DOCUMENTATION OF CODE STATUS AND WRITING LIMITATION OF RESUSCITATION ORDERS

A. Under either of the circumstances described in section II, the provider team should document the key aspects of the conversation(s) and decision(s) using the format provided in the electronic health record.
    1. These conversations should be documented **regardless of the decision to limit resuscitation.** For example, if full resuscitative efforts should be attempted, the conversations, decisions, values and goals should be documented and orders for attempting full resuscitation should be placed.
    2. Documentation of key components of the conversation and decisions should include:
        a. Names and roles of Individuals who participated in the conversation. If two or more providers were involved, all names should be listed.
        b. Current medical diagnoses and expected prognosis of patient.
        c. General content of the conversation(s) including the goals of medical care, values and preferences of the Patient/Parent(s).

d. Rationale for limiting CPR (if applicable), including the provider and Patient/Parent(s) perspectives.

3. Concise and clear description of medical interventions to be attempted or withheld, primarily determined by the provider within the context of the goals of care as discussed with the Patient/Parent(s).
4. The wording of documentation should be reviewed directly with the Patient/Parent(s) if possible to ensure clarity and understanding prior to finalizing.
5. During a single hospitalization, Limitation of Resuscitation Orders do not expire. However, they should be reviewed periodically when determined appropriate by the care team and Patient/Parent(s).

IV. COMMUNICATION REGARDING CODE STATUS AND LIMITATION OF RESUSCITATION ORDERS:

A. The provider entering a limitation of resuscitation order should verbally notify, in a timely manner, the Bedside Nurse and other involved medical providers of the conversation and decision to limit attempting CPR.

1. The Bedside Nurse verbally should notify the Charge Nurse.
2. The Bedside Nurse verbally should notify the Unit Coordinator, who should print a **hard copy** of the Limitation of Resuscitation Order to place with the Code Blue Resuscitation Sheet. These two documents should be available at the Patient's bedside at all times.
3. The Bedside Nurse verbally should notify the Respiratory Therapist and other Ancillary Services involved in the Patient's medical care.

B. When the Patient is transferred between different health care providers within the same hospital stay, the limitation of resuscitation orders will be communicated during provider hand off. Nurse to Nurse communication should occur in parallel to the provider communication.

C. A member of the medical team (Attending Physician, Fellow, or Resident Physician) should notify the Patient's Primary Care Provider in a timely fashion to ensure continuity of these discussions between the inpatient and outpatient setting.

V. WRITING LIMITATION OF RESUSCITATION ORDERS AND CODE STATUS AT ADMISSION

A. **Patient with NO prior history of a Limitation of Resuscitation Order**

1. In circumstances in which the provider team has a high level of concern for a possible life threatening emergency during a hospitalization, the provider team should follow the procedure for discussing and determining Code Status in a timely manner according to **Section II** and **Section III**. In the absence of such documentation at the time of a medical emergency, the treating medical team should provide appropriate medical care.

B. **Patient WITH a prior history of a Limitation of Resuscitation Order, Physician Order for Life-Sustaining Treatment (POLST), or Advance Directive**

1. The Admitting provider or Emergency Medicine provider should review the Code Status of the Patient with the Patient/Parent(s) upon admission according to the prior Limitation of Resuscitation Order, Physician Order for Life-Sustaining Treatment (POLST), or Advance Directive, and enter the limitation order for the current admission if unchanged.
2. If the Patient/Parent(s) **request substantial changes** to the Code Status or Limitation of Resuscitation Order, the provider must review all aspects of the resuscitation plan with the

Patient/Parent(s) to clarify the goals of care and wishes, values, and preferences of the Patient/Parent(s), following **Section II**, **Section III**, and **Section IV** of this Policy accordingly.

VI. LIMITATION OF RESUSCITATION ORDERS AND CODE STATUS AT DISCHARGE

A. At the time of discharge, the Code Status and Limitation of Resuscitation Orders should be reviewed by the provider team and Patient/Parent(s). The conversation and implications of the Limitation of Resuscitation Order should be documented in the Discharge Summary. This documentation should be clearly communicated with the Primary Care Provider.

B. The Patient/Parent(s) should be assisted by the provider team or Consulting Service (i.e. Pediatric Advance Care Team and/or Palliative Care or Hospice Providers) to develop a plan to manage the child if he or she suffers from cardiopulmonary arrest following discharge. Appropriate supportive resources, such as palliative care and hospice, should be in place prior to discharge if appropriate and consistent with family wishes and goals of care.

C. Providers may consider completing a Physician Order for Life Sustaining Treatment (POLST) form at the time of discharge. The POLST form is a set of **portable** physician orders that allow an individual to communicate his or her wishes regarding resuscitation, medical interventions, antibiotics, and artificial feedings in a variety of health care settings. Refer to **Appendix I** for specific guidelines for use of the Washington State POLST.

VII. DISCONTINUATION OR AMENDMENT OF LIMITATION OF RESUSCITATION ORDERS

A. Limitation of Resuscitation Orders may be rescinded or amended by the provider team and Patient/Parent(s) at any time. Prior to rescinding or amending the order, however, a detailed conversation between the provider and Patient/Parent(s) should occur. This conversation, including the rationale for rescinding or amending the order, should be documented in the electronic medical record. This documentation should be reviewed by the Patient/Parent(s) if possible prior to finalizing in the electronic records.

B. The provider making a change to the Limitation of Resuscitation Order should notify the Bedside Nurse and other members of the health care team of the modification in the Code Status and Limitation of Resuscitation Order as if a new Order were placed, as described in **Section II**, **Section III** and **Section IV**.

C. The Bedside Nurse should notify the Unit Coordinator and remove and/or replace the hard copy of the Limitation of Resuscitation Order at the Patient's bedside. Additionally, the Bedside Nurse should notify the other members of the health care team, as described in **Section III**.

VIII. OPERATIVE PROCEDURES AND INVASIVE INTERVENTIONS

A. When Patients with Limitation of Resuscitation Orders need to undergo invasive interventions or operative procedures, the Attending Physician, Anesthesiologist, Attending Surgeon(s), Attending Proceduralist(s), and Patient/Parent(s) should review the Code Status and Limitation of Resuscitation Order.

1. In many circumstances, cardiac arrest is more likely reversible when it occurs during anesthesia, meaning that in most circumstances, the patient will benefit from having the Code Status modified and Limitation of Resuscitation Order suspended during the intervention.
2. However, Limitations of Resuscitation Orders **do not necessarily** need to be rescinded prior to operative or invasive interventions. Several suggested approaches to determine the appropriate level of resuscitation in the OR include full resuscitation, limitation of resuscitation that is procedurally specific, or limitation of resuscitation based on a goal oriented approach, in which

the Patient/Parent(s) trust the Attending Anesthesiologist and Attending Surgeon and/or Proceduralist to determine which events are reversible and warrant full resuscitation versus events that are irreversible in which cardiopulmonary resuscitation has limited benefit.

B. Procedural Process:

1. In a Patient with a Modified Code Status, the Patient/Parent(s), Attending Anesthesiologist, Attending Surgeon or Proceduralist, and/or Primary Attending Physician should review and discuss the approach to address the Modified Code Status of the Patient during the operative or procedural intervention. Details of this conversation will be documented in the medical record prior to starting the operative or procedural intervention.
2. Modifications and/or Rescindment of the Limitation of Resuscitation Orders during the operative intervention should be documented and reviewed in the time-out procedure.
3. A hard copy of the unchanged or modified Limitation of Resuscitation Order should be printed, placed with the Code Blue Resuscitation Sheet, and accompany the patient to the operative or procedure room.
4. **PRIOR** to starting the procedure at the time of the Safety Time Out, the Code Status and Limitation of Resuscitation Order should be concisely described by the Attending Anesthesiologist and confirmed by the Attending Proceduralist and/or Attending Surgeon.
5. **DURING** the procedure or operation, the modified Code Status and Limitation of Resuscitation Order should be followed accordingly.
6. **AFTER** the operation or procedure, during the Hand Off process, the Attending Anesthesiologist and Primary Attending Physician should communicate any temporary revisions made to the original Limitation of Resuscitation Orders. If changes to the original limitation of resuscitation orders are to continue, the orders will be updated and a new hard copy of the Limitation of Resuscitation Orders will be placed with the Code Blue Resuscitation Sheet at the bedside of the Patient.

IX. LACK OF CONSENSUS REGARDING CODE STATUS AND LIMITATION OF RESUSCITATION ORDERS

A. In rare circumstances, conflict regarding Code Status and the Limitation of Resuscitation Orders may arise due to differing opinions regarding benefits and burdens. This may result in discord between the provider team and Patient/Parent(s). Maximal effort to clarify these differences in opinion through communication and support for all stakeholders should be prioritized. Detailed description(s) of any disagreements regarding the Code Status and Limitation of Resuscitation Order should clearly be documented in the electronic medical record.

B. When the lack of consensus between the provider team and Patient/Parent(s) persists, the approach to resolving the conflict depends on the urgency of the circumstances.

1. **Non-emergent:** Often time is helpful to allow Patient/Parent(s) and providers to reach agreement regarding the Code Status.
    a. While allowing time, the Code Status and Limitation of Resuscitation Orders should be documented according to the wishes and goals of the Patient/Parent(s).
    b. If possible, all conversations including, but not limited to, the introductory conversation regarding the possibility of limiting CPR or other interventions, Patient/Parent(s) values and preferences, goals of care, and decisions that are made, should be documented to maintain clarity and continuity throughout the process.

c. If necessary, explicit conflict resolution using **Bioethics P&P,** Withholding and Withdrawing of Life-Sustaining Medical Intervention When Disputes Arise, 11160 may be pursued.

2. **Emergent:** The Attending Physician has the primary responsibility to determine the relative benefits and burdens of medical interventions, including attempting CPR, according to the goals of care. The implementation, duration and cessation of resuscitation are medical interventions to be directed by the Attending Physician in the emergent setting.

X. **SPECIAL CIRCUMSTANCES**

A. **Limitation of Resuscitation Orders in children without a legal decision-maker: non-accidental trauma and maltreatment, abandoned, and unidentified children**

1. For children where there is not a clearly identified legal decision-maker, the SCAN team and social work should assist the provider team with identifying the legal medical decision maker for the child.
2. Until this person is appropriately identified, CPR should be performed in the setting of cardiopulmonary arrest if the benefits potentially outweigh the burdens as determined by the provider team.
3. Once the Legal Guardian is identified, the provider team should then communicate with the Legal Guardian(s) as discussed in **Section II** and follow this policy accordingly.

B. **Limitation of Resuscitation Orders and the Diagnosis of Brain Death**

1. When making the clinical diagnosis of brain death. See **Clinical P&P,** Determination of Death Based on Neurological Criteria (Diagnosis of Brain Death), 10350, the interim period between the first and second brain death examination presents a situation where resuscitation may not be medically appropriate, per the discretion of the Attending Physician. Under these circumstances, the Attending Physician should follow the formal process to write a Limitation of Resuscitation Order as described in **Section II**.
2. However, the Attending Physician should acknowledge that Parent(s) may have an interest in preserving the child's organs for potential organ donation. Hence, collaborative and explicit communication between the Attending Physician, the Organ Procurement Agency, and Parent(s) should occur when examining the potential benefits and burdens of attempting CPR.

C. **Limitation of Resuscitation Orders and Organ Donation after Cardiac Death**

1. When the decision is made to withdraw life sustaining therapy from a critically ill child, the Parent(s) may agree to organ donation after cardiac death, in consultation with the local Organ Procurement Agency. Please see **Clinical P&P,** Organ Donation After Circulatory Death (DCDD), 10752 .
2. Per the Donation after Cardiac Death protocol, a Limitation of Resuscitation Order is required at the time of withdrawal of the life sustaining therapy. This process should be explicitly explained to the Parent(s) by the Attending Physician in collaboration with the Organ Procurement Agency Representative. **Section II** should be followed accordingly by the Attending Physician.

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APPENDIX I :

A. **PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENTS (POLST)**

1. The POLST form is a physician order sheet is intended for any individual with an advanced life-limiting illness to effectively communicate his or her wishes to request or to limit life-sustaining medical treatment. The expressed wishes regarding resuscitation, medical interventions, antibiotics, and artificial feedings are translated into a set of portable physician orders that can be followed by health care providers in a variety of care settings. It is not an Advance Directive, such as a Health Care Directive, Living Will, or a Durable Power of Attorney for Health Care.
2. An outpatient clinic visit is the optimum setting for end-of-life care planning discussions, including review of the POLST. However, when a Limitation of Resuscitation Order is written during an inpatient stay, the Attending Physician may consider writing (or reviewing if written prior to admission) a POLST at the time of discharge.
3. There are limitations to the validity of using the POLST form for minors. See disclaimer in B.3 (below). However, Attending Physicians and Patients/Parent(s) may find the process of completing the POLST helpful in planning for the possibility of a medical emergency following discharge from the hospital and may choose to use the form as a communication tool.

B. **PROCEDURE FOR WRITING A POLST**

1. Request a POLST form from the Unit Coordinator.
2. Present the POLST form to the Patient/Parent(s) as an option. Additional patient and family education material, including a brochure on *Physician Orders for Life-Sustaining Treatment (POLST) Form* published by the WSMA and DOH, is available in the Patient and Family Education Database.
3. Washington statute provides liability protection to emergency personnel who rely on a POLST when the patient is an adult. **Pediatric patients and families** should be informed by the Attending Physician that Washington law does NOT authorize use of a POLST for Minors and the Washington Department of Health has advised all EMS personnel in the state of Washington that POLST is not applicable to minors.
4. The Attending Physician, if appropriate, should complete the document with the Patient/Parent(s). The Attending Physician must sign the form and assume full responsibility for its accuracy.
    a. Upon completion, the POLST should be compared to the Limitation of Resuscitation Order in the electronic medical record. These two documents should be congruent and reflect the wishes of the Patient/Parent(s).
    b. A photocopy of the POLST should be placed in the medical record. The POLST should not replace the Limitation of Resuscitation Order, which needs to be officially documented separately in the medical record.
    c. Similar to the Limitation of Resuscitation Order, the POLST needs to be updated with subsequent admissions and discharges. Outdated POLST forms should be discarded.

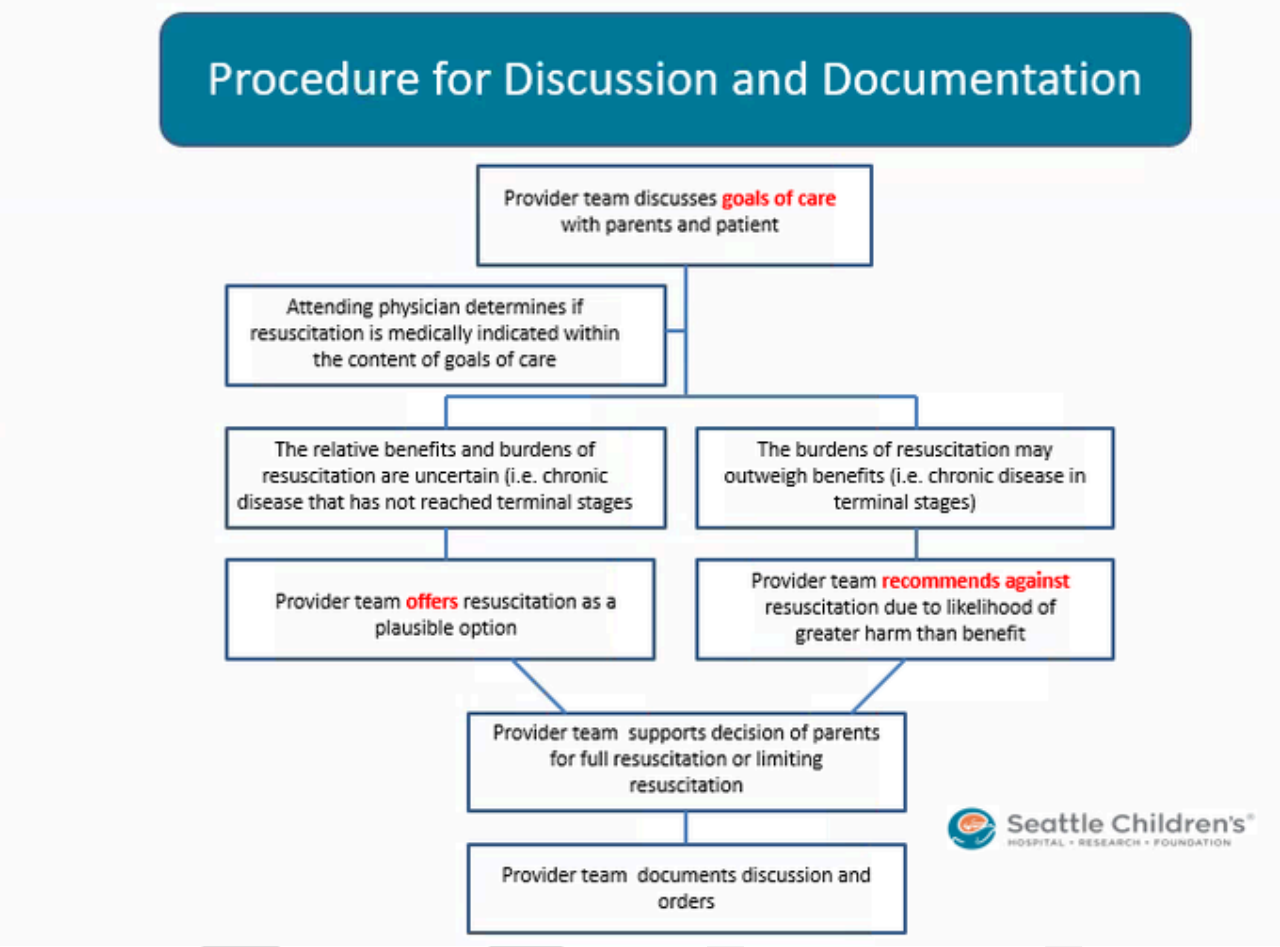
C. **HONORING POLST**

1. When an Adult Patient presents to the Seattle Children's Emergency Department with a valid POLST, Attending Physicians may in good faith rely upon the orders outlined by the POLST until a new Limitation of Resuscitation Order can be entered into the electronic medical record.
2. When a Minor Patient presents to the Seattle Children's Emergency Department with a completed POLST, full resuscitation will be provided until medical providers review and validate with Parent(s) and a new limitation of resuscitation order can be entered into the electronic medical record.

D. **REVIEW, MODIFICATION, AND REVOCATION OF POLST**

1. POLST forms should be reviewed in tandem with Code Status and Limitation of Resuscitation Orders among the primary decision makers, including the Attending Physician and Patient/Parent(s).
2. If modifications need to be made to the POLST, a new form should be used.
3. The Patient/Parent(s) can revoke treatment decisions on the POLST at any time. When a Patient's/ Parent(s)' current wishes and the POLST differ, the Patient's/Parent(s)' current wishes prevail.

APPENDIX I:



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Attachments

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Approval Signatures

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Release for Publication	Dale Landis: Director, Accreditation & Regulatory Compliance	2/19/2021
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	Ruth McDonald: VP - Chief Medical Operations Officer	2/14/2021

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