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| Title: Code Status Orders and Advance Directives | | | | Procedure | |
| Patient Age Group: | <input type="checkbox"/> N/A | <input checked="" type="checkbox"/> All Ages | <input type="checkbox"/> Newborns | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Adult |

DESCRIPTION

The purpose of this procedure is to describe the procedures for documenting a patient's code status and/or advance directive.

REFERENCES

- Policy, *Advance Directives and Patient Self-Determination*
- Policy, *Age of Majority and Emancipation of Minors*
- Policy, *Cardiopulmonary Resuscitation (CPR) Procedure, Documentation and Quality Improvement*
- Policy, *Patient Rights and Responsibilities*
- NMSA 24-7A-1 through 24-7A-18, *New Mexico Uniform Health Care Decisions Act*

AREAS OF RESPONSIBILITY

- Office of Clinical Affairs
- Nursing Council

PROCEDURE

1. **Code Status Orders**
 - a. Appropriate discussion of code status and advance directives with patients and families is encouraged.
 - b. A Code Status Order will ordinarily be considered only when a patient has an incurable medical condition or an irreversible terminal illness process such that all-inclusive life-sustaining efforts would not be medically indicated or appropriate, or would be futile.
 - c. If the patient has the capacity to make medical decisions, the order will be discussed with the patient and the patient must agree with the order before it is given.
 - d. If the patient has an advance directive, the patient's wishes as expressed in the advance directive will be respected pursuant to the New Mexico Uniform Health Care Decisions Act.
 - e. If the patient has been determined to lack the capacity to make medical decisions, the patient's guardian, agent or surrogate decision-maker pursuant to the New Mexico Uniform Health Care Decisions Act will be consulted and must agree with the order before it is given. If that guardian, agent or surrogate decision-maker disagrees with the patient's advance directive, the advance directive takes precedence, pursuant to the New Mexico Uniform Health Care Decisions Act.
 - f. When appropriate, an unemancipated minor patient should be involved in the decision-making process and may assent.
 - g. When appropriate, the wishes of the immediate family should also be considered in arriving at the decision.

- h. In the event of ethical conflicts or difficulties in decision-making, the treatment team may wish to consult with the Biomedical Ethics Committee to facilitate discussion and decision making.
- i. The Code Status Order will be written, signed, dated, and timed by the attending physician; or by the house officer or allied healthcare professional (AHP) with the approval of the attending physician after discussion. The circumstances surrounding the order will be documented in the patient's chart by the ordering practitioner. Documentation will include:
 - i. a summary of the medical situation;
 - ii. the outcome of consultation with other practitioners, if indicated;
 - iii. a statement summarizing the disclosure of information and outcome of discussions with the patient, guardian, agent or surrogate decision-maker, if such occurred.
- j. Nursing staff and clerical staff will follow usual procedures for taking off the order, and will also flag any existing physical chart to indicate that a Code Status Order is in effect.
- k. A Code Status Order remains in effect until an order cancelling the Code Status Order is written by the attending physician; or by the house officer or AHP with the approval of the attending physician after discussion. If a Code Status Order is cancelled, nursing staff and clerical staff will follow usual procedures for taking off the cancelling order, and will also remove any flags that had been placed on the patient's physical chart related to the cancelled Code Status Order.
- l. A Code Status Order, or an order cancelling a Code Status Order, must be handwritten in the paper chart, or entered into the electronic medical record, by the ordering practitioner. Verbal or telephone orders will not be accepted for initiation or cancellation of a Code Status Order.
- m. For the purposes of this policy, a Code Status Order stating 'Do Not Resuscitate' or 'No Code' means that in the event of a cardiopulmonary arrest, none of the following interventions will be initiated:
 - i. cardiopulmonary resuscitation (CPR)
 - ii. electrical defibrillation/cardioversion
 - iii. cardiac pacing
 - iv. mechanical ventilation
 - v. intubation (endotracheal or nasotracheal)
 - vi. manual bag/mask ventilation
 - vii. tracheostomy
 - viii. administration of medications for the purpose of cardiopulmonary resuscitation (this includes, but is not limited to, vasoactive agents, pressor agents, antiarrhythmic agents, or sodium bicarbonate).
- n. For the purposes of this policy, a Code Status Order stating 'Do Not Intubate' means that the patient will not be intubated (including endotracheally, nasotracheally, or through a tracheostomy). Other resuscitative efforts may or may not be implemented, in accordance with whatever other Code Status Order(s) or advance directives are in effect.
- o. The patient, or the patient's advance directive, or the patient's guardian, agent or surrogate decision-maker pursuant to the New Mexico Uniform Health Care Decisions Act, may also have decided that limited or less than full resuscitative effort should be made in the event of the patient having a cardiopulmonary arrest. In these circumstances, a 'Do Not Resuscitate' or 'No Code' order SHOULD

NOT be used. Instead, a Code Status Order should be written specifying what interventions are to be implemented or not implemented. A ‘Do Not Intubate’ order is an example of such a Code Status Order.

- p. This document should not be construed to mean that the therapeutic interventions commonly used during resuscitative efforts may not be used in the routine care of a patient exclusive of a cardiopulmonary arrest. For example, a patient with a ‘No Code’ order in place who develops a cardiac arrhythmia without cardiopulmonary arrest may still be treated with an anti-arrhythmic agent as part of routine patient care.
- q. Specific to patients undergoing procedures in the operating room or otherwise requiring general sedation or anesthesia, consent to the procedure and to the anesthesia includes consent to associated temporary intubation for administration of anesthetic agents and to sustain respiratory status during the procedure; and consent to temporary use of therapeutic interventions also associated with resuscitative efforts (e.g., the use of pressor agents). These temporary measures should not be seen as conflicting with a Code Status Order. The treating clinician may wish to clarify these matters with the patient, or with the patient’s guardian, agent or surrogate decision-maker, prior to the procedure.
- r. Whether or not a Code Status Order is in effect, every necessary measure will be taken to relieve the patient’s suffering and to maintain the patient’s comfort.
- s. In the event of a cardiopulmonary arrest, and if there is no Code Status Order in effect, cardiopulmonary resuscitation may be initiated when clinically appropriate.

2. **Advance Directives**

- a. When a treating clinician determines that the patient has an advance directive, the treating clinician will obtain a copy of the advance directive for inclusion in the patient’s medical record. The treating clinician will also document in the Problem List section of the patient’s medical record that an advance directive exists (e.g. “Advance Directive in Effect”).
- b. When a patient with an advance directive in effect is admitted, the admitting attending physician, house officer or AHP will include in the admission orders a statement that an advance directive is in effect. The admitting attending physician, house officer or AHP is also strongly encouraged to include in the admitting orders, progress notes, or admission history a statement about where the advance directive may be located (e.g., “A copy of the advance directive is in the Legal section of the patient’s chart.”).
- c. The patient’s treatment team will familiarize themselves with the contents of the advance directive.
- d. When discussing an advance directive with a patient, family members, surrogate or guardian, the clinician may wish to consider discussion of code status, including cardiopulmonary resuscitation; resuscitative medications; cardiac pacing; intubation; mechanical ventilation; enteral or parenteral feeding; ongoing IV fluid use; dialysis; blood transfusion; and invasive procedures or surgeries. Clinical judgment is, however, always the first guide in any such discussion.
- e. The treatment team may also wish to review the University Hospitals policy *Advance Directives and Patient Self-Determination*, and NMSA 24-7A-1 through 24-7A-18, *New Mexico Uniform Health Care Decisions Act*.

DEFINITIONS

1. ‘Code Status Order’ – A code status order is a medical order for the resuscitative efforts a patient (or patient’s surrogate) wishes to occur, or not to occur.
2. ‘Advance Directive’ – An advance directive is a statement of instructions for health care made by a person with capacity. In particular, an advance directive usually states the person’s wishes for health care in the event that they develop a seriously debilitating or terminal illness.
3. ‘Allied Healthcare Professional’ (AHP) – For the purposes of this document, an AHP is an advanced practice nurse or physician assistant who is a member of the associate medical staff and a member of the patient’s treatment team.
4. ‘Capacity’ – Capacity is an individual’s ability to understand and appreciate the nature and consequences of proposed health care, including its significant benefits, risks and alternatives to proposed health care; and to make and communicate an informed health-care decision.

SUMMARY OF CHANGES

Replaces the previous policies, “No Code or DNR” and “Do Not Resuscitate in Operating Room”.

RESOURCES/TRAINING

- Biomedical Ethics Committee
- Office of Risk Management
- Office of Clinical Affairs
- Office of University Counsel

DOCUMENT APPROVAL & TRACKING

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