

Guidelines for Do-Not-Resuscitate Orders

Cardiopulmonary resuscitation should be initiated in the event of sudden or impending death unless there is a properly executed Do-Not-Resuscitate (DNR) Order or a contraindication to performing CPR as outlined in Section 3 below, as determined by the patient's attending physician. These guidelines address situations where DNR orders are appropriate and how such orders are to be documented and executed.

A. Cardiopulmonary Resuscitation (CPR) as a Medical Therapy

1. What is CPR?

Cardiopulmonary resuscitation, or CPR, is a set of emergency procedures (often set in motion by calling a "code") performed on persons during cardiac and/or respiratory arrest. When a patient's heart stops beating effectively and/or breathing stops, CPR is an attempt to restore functions of the heart and lungs through the use of chest compressions, artificial respiration, medications and electrical shock(s). The types of procedures performed and the duration of the resuscitation attempt are not standard but must be individualized to each patient's circumstances.

Cardiopulmonary resuscitation may not always be in a patient's best interest and may be withheld when there is agreement between the caregivers and the patient or surrogate decision-maker that the expected benefits of cardiopulmonary resuscitation would not exceed the attendant risks and burdens. In addition, a competent patient has the legal right to refuse medical treatment, even if it is potentially life-saving.

2. When to use CPR

From a medical standpoint, CPR is a therapy designed for a patient who has a potentially reversible cardiopulmonary arrest and for whom there is a reasonable possibility of therapeutic benefit.

3. When not to use CPR

a. Refusal of CPR by competent adult patients

Competent adults have the legally protected right to be fully informed about the risks and benefits of all alternatives for treatment and to consent to or refuse any medical treatment, including CPR.

b. Physiologically futile CPR

CPR should not be performed when it would be physiologically futile; that is, when it would not work. CPR is not designed for use in patients whose medical condition makes resuscitation and mechanical ventilation ineffective. For such patients, an order that CPR not be attempted (DNR order) may be entered in the medical record, as more fully discussed in Paragraph D below.

c. Non-therapeutic CPR

CPR is also not designed for use in patients for whom CPR is not therapeutic – that is, those patients in whom CPR cannot reverse the on-going dying process or will not provide therapeutic benefits that outweigh the harms or substantial burdens of CPR ("non-therapeutic CPR"). By way of example, cardiopulmonary arrest is an

expected terminal occurrence in patients with certain diseases or conditions who are nearing the end of their life span. In such cases, CPR may temporarily restore cardiac function but the patient's overall condition will worsen and cardiopulmonary arrest will occur again as a natural and inevitable part of the dying process. Providing CPR in such cases is likely to harm the patient and contravenes the medical ethics (including the principle of "do no harm") of clinicians. For such patients, a DNR order is appropriate so that CPR will not be attempted.

B. Role of Patient and Parents of Minor Children

The patient and parents (or legal guardian)* should be involved in making decisions about CPR. As with other clinical decisions, parents of minor children should be fully informed about medical recommendations regarding CPR and DNR, and minor children should participate to the fullest extent of their developmental abilities and emotional state. Generally, a DNR order should not be entered into the patient's medical record without concurrence of the parents. However, a DNR order may be entered by the patient's physician without parental permission if CPR is determined to be physiologically futile or non-therapeutic, in accordance with Paragraphs E and F below.

C. Documentation of a Do Not Resuscitate (DNR) order

Documentation in the patient's medical record of a decision not to do CPR must include both a Physician's Order and an entry in the Progress Notes. Use of the [standardized DNR Order Form](#) is preferred, but is not required in cases where the attending physician prefers a narrative method of documentation.

Documentation in the Progress Notes should include the following and be written or co-signed by the attending physician:

1. Why and how the initial question of resuscitation status was raised.
2. Decision making process which has been and will be followed:
 - a. Professional staff involvement;
 - b. Role of parents and patient;
 - c. Data upon which decision is based.
3. Summary and update of planning process and decision.
4. Summary of conversations with patients and parents.

Subsequent progress notes should document re-evaluation of the patient's condition on a timely basis, continued appropriateness of the DNR order, and family involvement.

Discussion(s) regarding resuscitation status with the patient and/or family are the responsibility of the attending physician. The Physician's Order, whether utilizing the [standardized form](#) or a narrative format, must be signed by an attending physician and nurse. When the patient's attending physician is not immediately available to sign the order, then a house staff physician may sign the order, after conferring with the attending physician over the phone to verify the appropriateness of the order, and document this conversation in the chart. Under these circumstances, the attending physician must physically sign the form as soon as possible and in any case no later than 24 hours after the order is entered into the patient's medical record. In addition, an expiration date, if any, should be set forth in the orders.

* In the remainder of this policy, the term "Parent(s)" will be used to refer to the legally authorized decision-maker(s) for a child and should be understood to refer to the legal guardian when appropriate. When the patient is a competent adult, the patient is the legally authorized decision-maker.

The primary nurse and attending physician (or their designees) are responsible for ensuring that all pertinent caregivers are aware of the DNR Order. Whenever possible, medical and nursing staff from other units or facilities who will be providing care, or who will resume care, should be involved in discussions about a DNR Order to enable understanding and continuity of care.

D. Entry of DNR order in cases of disagreement between clinical staff and parent(s)

In almost all circumstances, parents and clinical staff should reach agreement about whether a DNR order is appropriate for the patient based on the patient's prognosis, the risks of harm and potential benefits, if any, that may be expected of CPR, and the values of the parent(s) and patient. Nevertheless, on rare occasions, parents may request CPR even though the clinical team has concluded that CPR is either physiologically futile or not therapeutic. The process for dealing with such disagreements depends on the reason CPR is considered inappropriate.

When there is agreement among clinical staff caring for the patient (i.e. the clinical team) that **CPR is physiologically futile**, parents should be informed and told that a DNR order will be written in the chart. Parents who disagree with the clinical decision not to do CPR should be given a reasonable opportunity to obtain a second opinion or transfer the patient unless the child's condition precludes doing so. Clinical staff are not required to perform physiologically futile and harmful treatments on a patient.

When there is agreement among clinical staff caring for the patient that **CPR is non-therapeutic** and that performing CPR violates their medical-ethical duty to the patient, and if parents still want CPR to be performed, the clinical team should initiate a process of review to determine whether a DNR order may be entered despite the disagreement of the parent(s).

E. Process for reviewing disagreements about whether CPR is therapeutic

If the patient's clinical team has concluded that performing CPR on the patient would not be therapeutic, and if the team has been unable to reach agreement with the parents about entering a DNR order, then staff and/or parents should initiate the following review process:

- a. The clinical staff should confirm that members of the patient's clinical team are in agreement that CPR should not be performed on the patient because it is non-therapeutic.
- b. A second opinion should be obtained from a physician not on the patient's clinical team about whether CPR is non-therapeutic.
- c. If the second opinion supports the conclusion of the clinical team, a member of the clinical team should contact the Ethics Office to schedule an ethics consult.
- d. Hospital staff will work actively with the patient's parent(s) and other care providers (such as the patient's primary care physician, school nurses, group home staff, etc.) to appreciate their concerns and plan for care without CPR.
- e. If the ethics consult supports entry of a DNR order despite the parents' disagreement, the clinical staff should inform the Chief of Service and the Legal Office.
- f. If the Service Chief concurs, and if the legal office confirms that judicial involvement is not necessary, the parents should be told that a DNR order will be entered into the patient's medical record.
- g. Parents should be given a reasonable opportunity and assistance to transfer the patient to another facility willing to accept the patient.

- h. If it is not possible to transfer the patient, a DNR order may be entered into the patient's medical record.

F. Mandatory Reassessment of DNR Orders Before Anesthetic and Surgical Procedures

Patients with DNR orders may be appropriate candidates for anesthesia and surgery, especially for procedures intended to facilitate care or relieve pain. The etiologies and outcomes of cardiac arrest during anesthesia are sufficiently different from those in non-surgical settings that re-evaluation of the DNR order is always necessary. The fact that cardiac arrest is more likely to be reversible when it occurs during anesthesia will often mean that it is in the patient's best interest to have the DNR order suspended during the intra-operative and immediate post-operative periods. In some cases, however, patients or their parents may desire limitations on the resuscitative procedures used throughout the perioperative period.

The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. For example, routine anesthetic care usually requires placement of an intravenous catheter, administration of intravenous fluids and medications, and management of the patient's airway and respiration. Chest compressions and electrical cardio-version, on the other hand, are generally not intrinsic to the anesthetic or surgical procedure.

The anesthesiologist, in conjunction with the patient's other attending physicians, is responsible for discussing these issues with the patient and/or family, reassessing the patient's DNR status prior to surgery, and communicating these decisions to those who will be involved with the patient's care during the intra-operative and immediate post-operative period.

The hospital's standardized DNR Order form may not be the best tool for considering and documenting DNR status during the perioperative period. Alternatively, agreement with the patient and/or family on one of the following three options may meet the needs of most patients with DNR status who require anesthesia and surgery:

Option #1: Full Resuscitation

The patient desires that full resuscitative measures be employed during surgery and in the PACU, regardless of the clinical situation.

Option #2: Limited Resuscitation: Procedure-Specific

The patient desires that full resuscitative measures be employed, with the exception of certain specific procedures, such as chest compressions or electrical cardio version. As noted above, however, certain procedures are essential to providing the anesthetic care (such as airway management and intravenous fluids). Refusal of these procedures would not be consistent with a request for anesthesia and surgery.

Option #3: Limited Resuscitation: Goal-Specific

The patient desires resuscitative efforts during surgery and in the PACU only if the adverse clinical events are believed to be both temporary and reversible, in the clinical judgment of the attending anesthesiologists and surgeons. This option requires the patient and/or surrogate to trust the judgment of the anesthesiologists and other caregivers to use resuscitative interventions judiciously, based upon their understanding of the patient's values and goals of treatment.

One of the options outlined above, or another if appropriate, should be documented in the Progress Notes. The original DNR order should be reinstated at the time the patient leaves the care of the anesthesiologist (upon transfer out of the OR or PACU), unless otherwise documented.

If the patient/parent(s) elects to have the DNR order remain in effect during anesthesia and surgery, physicians and other caregivers have the option of declining to participate in the case. Should any caregiver decline to participate, he or she must make a reasonable effort to find another who is willing to treat the patient.

G. Patients who are 18 or Older

As a general rule, patients who are 18 years of age or older are entitled to make decisions on their own behalf. However, in certain cases, when children over the age of 18 are not able to make their own decisions (are “incapacitated”), parents may be authorized to make decisions on their behalf.

1. Parents of children who are mentally incapacitated may have been given authority by the court to serve as guardians for their children.
2. Parents may have been designated health care agents or proxies in their adult child’s advance directive after the child turned 18, and thus are authorized to make decisions when their child is no longer capable of doing so.
3. In certain circumstances, even absent a court order or an advance directive, parents may be the appropriate surrogates for their adult child (just as a spouse or child may be the appropriate surrogate for an adult who has not completed an advance directive). By way of example, parents of a child with a chronic, degenerative illness may be the appropriate surrogate for their child in the event a decision must be reached about DNR and the child no longer has decision-making capacity (but did not complete an advance directive). Parents may also be the appropriate surrogates for a child over 18 who become ill or injured unexpectedly and is unable to make decisions on his/her own behalf. Legal counsel should be contacted in these circumstances.

H. Discontinuation of a DNR Order

A DNR order may be revoked by a competent patient or surrogate decision-maker, unless the DNR order has been entered because CPR is physiologically futile, or because it has been determined to be non therapeutic, provided the review process set forth in Paragraph E has supported such determination. Any member of the clinical staff or family may request that a DNR order be re-evaluated. Discontinuation of the DNR order must be noted in the appropriate place on the DNR Order Sheet (or documented in the Physician’s Orders if a DNR Order Sheet is not used), and explained in the Progress Notes.

I. Ethical Concerns

The Hospital Ethicist and Ethics Advisory Committee are available to any member of the health care team, family, and patient, for advice about ethical concerns, including decisions about resuscitation or other life-sustaining treatments. The Office of Ethics can be reached at x6920 and an Ethicist is always available by pager.

J. Legal Considerations

If clinical staff believe legal consultation is necessary or might prove helpful, an attorney with the Hospital's Office of General Counsel should be contacted at x6800 or, if urgent, by pager. For example, when a child is in state custody through Massachusetts Department of Children and Families, an ethics committee consultation and court review of decisions to limit life-sustaining treatments is legally required. Hospital counsel might also be consulted when guardians or attorneys are involved on behalf of the child and/or parent(s), or when there are concerns about conflict, consent or documentation.

K. DNR orders for Emergency Medical Technicians (EMTs)

The Massachusetts Department of Public Health's Office of Emergency Medical Services has developed the COMFORT CARE DNR Verification program to provide a mechanism for EMTs and First Responders to identify patients who have DNR orders and to initiate a protocol focused upon comfort and palliative care rather than automatic emergency CPR. The patient's DNR status is indicated by a standardized state form that must be immediately available to EMS personnel and/or an orange bracelet on the patient's arm. The attending physician is responsible for determining whether a patient needs a DNR verification order and for completing the CC/DNR Form and Bracelet, providing a copy for the parent(s) and placing a copy of the CC/DNR form in the patient's medical record. The appropriate forms and informational brochures are available on the Critical Care units, or may be obtained from the MICU Office (x7327), the Office of Ethics (x6920), the Office of General Counsel (x6800), or online at <http://www.mass.gov/eohhs/provider/guidelines-resources/clinical-treatment/comfort-care/>

Since the CC/DNR program applies only to EMTs and First Responders, the attending physician may also want to provide a statement on the physician's letterhead and/or a copy of the Children's Hospital DNR form to provide non-binding guidance to others who may need information regarding the patient's resuscitation status, such as visiting nurses or emergency physicians at Children's Hospital or other institutions. As a general rule, valid CC/DNR Forms or Bracelets will be honored by the medical and nursing staff of Children's Hospital Emergency Department and in the Children's Hospital Ambulatory Clinics.

Approved MSEC 9/98

Revised 7/99

Revised /2009

Approved MSEC 1/2012