Code Status (Options for Care)

1. Introduction

Providence Health Care ("PHC") is a Catholic health care organization that respects and promotes the sacredness of life from conception until natural death.

This policy, in conjunction with the Advance Care Planning and Serious Illness Conversations policy, will help ensure that all conversations between patients, residents, families, and their health care providers that are devoted to goals of care, Code Status, quality of life, and risks and benefits of the resuscitation process shall be held in a spirit of compassionate, person and family-centred care and shared decision-making.

1.1. Purpose

The purpose of this policy is to establish a framework for determining and documenting a patient or resident's Code Status which reflects the patient or resident's goals of care and is developed through a shared decision-making process among the patient or resident, in some cases their substitute decision maker, and their Health Care Providers (HCPs).

Code Status provides a standardized format for communicating the scope of health care that has been agreed to between patients, residents, or their substitute decision makers, and their HCPs.

1.2. Scope

This policy applies to all PHC staff and medical staff providing health care to admitted patients in acute care, residents living in long-term care homes and attendees of outpatient clinics where appropriate.

2. Policy

HCPs will assist patients and residents or their substitute decision makers ("SDM") in making an informed decision about their Code Status by initiating, facilitating, and engaging in conversations that:

- help to ensure an understanding of the patient and resident's goals of care; and
- ensure the patient, resident or their substitute decision maker has sufficient information about the probable outcomes, benefits and risks of the resuscitation process as they relate to the patient or resident's goals of care to make an informed choice.

The patient or resident's Code Status (previously referred to at PHC as "Options for Care" and referred to elsewhere in British Columbia as Medical Orders for Scope of Treatment or MOST) will be documented in the patient or resident's health record.

Code Status is documented as one of the following:

Title	Description
Attempt Cardiopulmonary Resuscitation (CPR), Full Code	
1-No CPR, Supportive Care, No Intubation	No CPR. Supportive care, symptom management, continued management of chronic conditions, and comfort measures. Allow natural death.
2-No CPR, Therapeutic Care, No Intubation	No CPR. Option 1 plus therapeutic measures and medications to manage acute conditions within the current setting.
3-No CPR, Acute Transfer, No Intubation	No CPR. Option 2 plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.
4-No CPR, Critical Care, No Intubation	No CPR. Maximum therapeutic effort as in Option 3 including referral to Critical Care but not intubation and/or ventilation.
5-No CPR, Critical Care, May Intubate	No CPR. Maximum therapeutic effort as in Option 4 including referral to Critical Care and including intubation and ventilation.

Conversations related to the patient or resident's Code Status must be recognized as an ongoing process, not as a single event, in which HCPs and the patient, resident, or substitute decision maker reassess goals of care over time and as the patient or resident's circumstances change.

At a minimum, the patient or resident's Code Status will be reviewed when:

a. the patient, resident, or their substitute decision maker asks for a review or indicates in conversation that he or she may have changed his or her mind about their Code Status;
b. there is a significant change in the patient or resident's health condition that may not have been considered in previous advanced care planning;

c. any member of the health care team or the patient, resident, substitute decision maker, significant other, or member of their family believes there is reason for review;
d. the patient or resident transfers between institutions or upon readmission to a facility;
e. the patient or resident who has a no CPR order is considered for surgery or interventional procedures; or
f. the annual care conference for residents takes place.

When a decision is made to change a patient or resident's Code Status, the new Code Status must be documented in the health record and, where Cerner has been implemented, signed by a physician.

3. Guiding Principles

3.1. Do Not Attempt CPR

A Do Not Attempt CPR decision may be appropriate when:

- resuscitation is against the express wishes of a capable patient or resident, or a duly appointed Personal Guardian or Representative, if the patient or resident is not capable of decision making and/or in accordance with a valid and applicable Advance Directive;
- the clinical team believes that resuscitation will fail to restart the heart/breathing;
- the clinical team believes that resuscitation will simply prolong dying as the sole outcome with no other identifiable physiological benefits and/or;
- the resuscitation attempt is unlikely to achieve the patient or resident's goals of care.

3.2. Code Status in Acute Care Settings

HCPs will initiate CPR in the event of an arrest (witnessed and unwitnessed) unless a discussion between the HCPs and the patient or their SDM has deemed CPR inappropriate and that decision is reflected in the Code Status documented in the patient's health record. In the absence of a documented Code Status the patient will be treated as a full code.

Within 48 hours of admission, HCPs will engage patients (or their SDMs) in a discussion to determine a patient's Code Status.

For all procedures where cardiac arrest is a foreseen risk, Code Status shall be discussed as part of the process of informed consent.

Each clinical area will determine the appropriate procedure for initiating conversations with patients or their SDM. If the most responsible provider ("MRP") is not the HCP initiating the conversation with the patient, consultation with the MRP is **required** prior to completion of the Code Status. For all sites using Cerner, the Code Status must be signed by a physician.

3.3. Code Status in Long-Term Care Settings

Code Status shall be discussed with the resident or their SDM prior to the resident moving into the long-term care home or, if this is not possible, within the first week of moving into long-term care.

In a witnessed arrest CPR will be attempted unless the HCPs and the resident (or their SDM) have reached a decision not to attempt resuscitation and the Resident's Code Status has been updated in their health record to reflect the decision.

In an unwitnessed arrest, CPR will not be attempted regardless of the resident's Code Status. The resident and, if applicable, their SDM must be informed of the distinction between a witnessed and unwitnessed arrest as part of the informed consent process.

Each site will determine the appropriate procedure for initiating conversations with residents or their SDM. If the MRP is not the HCP having the conversation with the Resident, consultation with the MRP is **recommended.** The Resident's Code Status must be documented in the health record and, if using Cerner, signed by a physician. If the physician signing the Code Status is not the MRP, the MRP should be notified of any change to the Resident's Code Status.

3.4. Substitute Decision Maker

If the patient or resident is not capable of making a decision regarding their Code Status, decisions will be made in consultation with the SDM (see Consent to Health Care policy).

3.5. Temporary Change in Code Status

Regardless of the Code Status determined in section 3.2, acute care patients will revert to full Code Status for surgery and interventional procedures for the period of time that they are away from their usual care setting to have the surgical or interventional procedure. As part of the informed consent process, the surgeon will ensure that the patient or SDM is aware that the patient will be a Full Code.

In exceptional circumstances, where the patient or SDM wants to proceed with the surgery but does not want CPR attempted, the surgeon may make an exception and designate the patient as No CPR even during the period of the surgery or intervention. This decision must be properly documented in the health record.

Once the patient returns to the usual care setting (i.e. the patient has returned to the care unit from post anesthetic recovery), the patient's Code Status prior to the surgery or interventional procedure will resume unless otherwise specified by the MRP.

3.6. Dispute Resolving Mechanism

Differences of opinion between HCPs, patients, residents, or an SDM regarding a patient or resident's Code Status should be approached in a respectful and constructive manner.

HCPs shall make every attempt to avoid an impasse by engaging in regular and sustained discussion with one another and the patient, resident or SDM.

In circumstances where disagreement about Code Status occurs, HCPs shall attempt to clarify any factual misunderstanding through the sharing of information and education.

When a dispute remains unresolved, the MRP may transfer the case to another physician who agrees with a different approach, or seek a second opinion from an alternate provider. Alternatively, those involved may meet as a group with the PHC ethicist and/or risk manager to attempt to resolve the matter.

In the event there is ongoing disagreement and the patient or SDM is demanding aggressive resuscitation that is not supported by the MRP, Risk Management is to be contacted.

The usual course, assuming fulsome discussions with the patient, resident or SDM and the HCPs have occurred, will be that current therapy should continue but the patient, resident or SDM MUST be advised of the escalated treatment options, including CPR, that will not be offered. The MRP may accordingly change the Code Status based on their best clinical and professional judgment, and must inform the patient, resident and/or SDM of the change. Risk Management may be contacted to inform the patient, resident or SDM of their right to seek legal advice, but the direction for care will not change in the intervening time.

If the patient is already receiving critical care, and there is a disagreement about escalation, resuscitation or withdrawal of care, the usual process will be that the patient, resident or SDM will be advised that the current Code Status will be continued for a period of 48 to 72 hours (depending on the day of the week and availability of the Courts) while the patient, resident or SDM seeks an injunction compelling the care team to provide the care as requested. In the event this time expires with no initiation of legal resolution, or no affirmation from the Courts, the MRP can change the Code Status unilaterally.

4. Compliance

Care provided contrary to a patient, resident, or SDMs known preferences, or provided without a conversation as described, is a breach of this policy and an infringement on the rights of patient and residents and may result in disciplinary action and/or legal consequences.

5. Supporting Documents

Related Policies

Advance Care Planning/Serious Illness Conversations
Consent to Health Care

Guidelines/Procedures/Forms

Hemodialysis: Cardiac Arrest (Code Blue) Procedure in Community Dialysis Units
My Voice: Expressing my wishes for future health care treatment. Advance care planning guide (2013).
Serious Illness Conversation Guide
Serious Illness Conversations – tools and resources

6. Definitions

"Advance Care Planning" is the process of a capable adult talking over their beliefs, values, wishes or instructions about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions. This planning is an ongoing process, not a single event, where the patient/resident can reassess their wishes as circumstances change.

"Advance Care Plan ("ACP")" is a written or otherwise communicated summary of a capable adult's wishes or instructions to guide a substitute decision maker if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult.

"Advance Directive" is a capable adult's written instructions that speak directly to their health care provider about the health care treatment the adult consents to, or refuses. It is effective when the capable adult becomes incapable and only applies to the health care conditions and treatments noted in the advance directive.

"**Cardiopulmonary resuscitation ("CPR")"** is an emergency procedure used to revive someone when their heart and/or lungs stop working unexpectedly. CPR can include repeated

compressions to the person's chest and rescue breathing to inflate the person's lungs and provide oxygen.

"Code status" refers to the shared health care provider, patient, resident, (or substitute decision maker's) decision regarding whether or not to initiate CPR and if CPR is not initiated (DNAR) further directions on care in the event of a serious illness or sudden collapse.

Code status is documented as one of the following:

Attempt CPR, Full Code	
1-No CPR, Supportive Care, No Intubation	No CPR. Supportive care, symptom management, continued management of chronic conditions, and comfort measures. Allow natural death.
2-No CPR, Therapeutic Care, No Intubation	No CPR. Option 1 plus therapeutic measures and medications to manage acute conditions within the current setting.
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4-No CPR, Critical Care, No Intubation	No CPR. Maximum therapeutic effort as in Option 3 including referral to Critical Care but not intubation and ventilation.
5-No CPR, Critical Care, May Intubate	No CPR. Maximum therapeutic effort as in Option 4 including referral to Critical Care and including intubation and ventilation.

"Health Care Provider ("HCP")" is a person who, under a prescribed BC Act, is licensed, certified, or registered to provide health care in British Columbia.

"Most Responsible Provider ("MRP")" is the person who has the overall responsibility for the management and coordination of the care of the patient at any given time.

"Serious Illness Conversations" " are those that address planning in the context of serious illness progression. These conversations should include an assessment of patient or resident's understanding and information preferences, prognosis, an exploration of the patient's goals, fears, priorities, acceptable trade-offs, and family understanding.

"Spouse" is a person who: a. is married to another person, and is not living separate and apart, (within the meaning of the Divorce Act (Canada), from the other person; or b. is living and cohabiting with another person in a marriage-like relationship, including between persons of the same gender

"Substitute Decision Maker (also known as "SDM")" means a capable person with the authority to make health care treatment decisions on behalf of an incapable adult, which includes a Personal Guardian (Committee of the Person), a Representative or a Temporary Substitute Decision Maker as defined below in ranking order:

1. **Personal Guardian (Committee of the Person)** means a person appointed by court order of the Supreme Court of B.C. under the Patients Property Act, giving them broad decision-making powers on behalf of the patient/resident. This order will usually be in force for a long period of time.
2. **Representative** means a person 19 years or older who is named by a capable adult, in a Representation Agreement, to make health care treatment decisions on their behalf when they are incapable of decision making.
3. **Temporary Substitute Decision Maker (TSDM)** means a person temporarily appointed under the Health Care (Consent) and Care Facility (Admission) Act as a substitute decision-maker if the patient or resident does not have a previously appointed Personal Guardian or Representative.

7. References

1. Health Ethics Guide 3rd Ed. Catholic Health Alliance, 2012
2. Health Care (Consent) and Care Facility (Admission) Act

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