GUIDELINE

Title:	COVID-19: Attempted Cardiopulmonary Resuscitation (“CPR”)				
Department/Service Line:	Clinical				
Approver(s):	Clinical Ethics; Legal and Risk Management				
Location/Region/Division:	BSWH				
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SCOPE

This document applies to Baylor Scott & White Health including Controlled Affiliates (“BSWH”).

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

Person Under Investigation (a.k.a. PUI) - a Person Under Investigation is any person whom the physician judges to be at risk of possible COVID-19 infection, whether investigative testing has been initiated at the time the physician is making the judgement.

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1. HCPs have always accepted a duty to treat even at some personal risk (AMA CEJA Opinion 9.067), but the duty to treat does not require personal recklessness. The potential overall benefit of CPR (for example, reported survival to discharge of <1% when attempted in the nursing home, <5%when attempted at home and <25% when attempted in the acute care hospital) must be balanced with the HCPs stewardship duty to protect scarce resources – in this case the resource of professional availability. Because attempted CPR creates significant exposure risk in actual or potential COVID-19 infection, a potential14-day furlough of those exposed is required, meaning these professional are then unable to serve any patient. In times of overwhelming demand, serving the greatest number of persons in need of medical care makes it ethically unacceptable to not use PPE.
2. Professional integrity and devotion to serving all persons with the most appropriate interventions for the circumstances in question creates an ethical obligation for physicians to favor clinical decisions based on evidence-based medicine and approved clinical guidelines over individual patient or surrogate preferences, similar to how organ transplantation medicine is practiced. Not every person who would like to receive an organ transplant will receive an organ transplant. Similarly, not every person or surrogate who would like to receive CPR will receive it.
3. We will not arbitrarily deny attempted CPR merely because of actual or suspicion of COVID-19 infection, but:
    - We accept that when CPR is attempted in any setting, because PPE must be donned, there will be a time delay similar to initiating ACLS protocol in the community, leading to worse outcomes compared to usual hospital-based CPR for some individuals. This is justified by the demands of stewardship and protection of the many. Patients and surrogates should be informed of this dire outcome and counseled that DNAR/COT is most appropriate in progressive COVID-19 infection.
4. In the event of Mass Critical Care Guideline implementation and although life sustaining treatment that cannot be provided to a patient without denying the same treatment to another patient is not required (Texas Health and Safety Code 166.009), there remain other laws impacting the placement of DNAR orders on hospitalized patients.

- If the hospital has reached triage level blue or red and in the reasonable judgment of the physician CPR will not lead to survival (for example MOSF or widely metastatic cancer), CPR should not be attempted and a DNAR/COT order should be entered, as supported by:
  - Validation methods number 1 to 7 if the patient or legal representative is supportive of a DNAR order; or,
  - If validation of the DNAR order via methods 1 – 7 cannot be obtained in a timely fashion or obtained at all, then a unilateral informed DNAR/COT order under validation method number 8 should be issued. When issued while operating under the Mass Critical Care Guidelines, the order should be based on reasonable medical judgment the patient's death is imminent regardless of the provision of CPR and the DNAR order is medically appropriate; and, a reasonable diligent effort to provide notice that the DNAR order will be entered. The requirement under normal circumstances for Validation Method 8 that the patient has not previously requested full code status is waived when operating under the Mass critical Care Guidelines.
- If a triage decision has been made to withdraw life sustaining treatment because a patient is now too ill (MSOFA >11 and/or physician judgment) and mechanical ventilation and other life-sustaining treatment is being withdrawn, then a DNAR/AND order should be written, as supported by:
  - Validation methods number 1 to 7 if the patient or legal representative is supportive of a DNAR order; or,
  - If validation of the DNAR/AND order via methods 1 – 7 cannot be obtained in a timely fashion or obtained at all, then a unilateral informed DNAR/AND order under validation method number 8 should be issued. When issued while operating under the Mass Critical Care Guidelines, the order should be based on reasonable medical judgment the patient's death is imminent regardless of the provision of CPR and the DNAR order is medically appropriate; and, a reasonable diligent effort to provide notice that the DNAR order will be entered. The requirement under normal circumstances for Validation Method 8 that the patient has not previously requested full code status is waived when operating under the Mass critical Care Guidelines.

4. In the event of Mass Critical Care Guideline implementation and although life sustaining treatment that cannot be provided to a patient without denying the same treatment to another patient is not required (Texas Health and Safety Code 166.009), for the Emergency Department (ED):
   - Physicians and advance practice professionals may need to make the difficult decision not to attempt CPR if in their reasonable medical judgement, CPR will not lead to survival to discharge, and/or the patient experiencing cardiac/respiratory arrest is a PUI and/or patient with confirmed COVID-19 and PPE is not available.
   - The ED is not required to enter DNAR orders and/or utilize the DNAR Validation form.
5. Ethics consultation may be requested if objections arise.

PROCEDURE

During this time of widespread COVID-19 infection:

1. Healthcare personnel (HCP) attempting cardiopulmonary resuscitation (CPR) and related events (rapid response and intubation) on patients under investigation (PUI) of COVID-19 or patients with confirmed COVID-19 must wear personal protective equipment (PPE) before attempting CPR as follows:
   - N95 masks with goggles *or* Powered Air Purifying Respirators (PAPRs), and
   - Gown and double glove before entering the room.
2. The number of HCPs entering the room should be limited to 4 -5 persons *commensurate with local facility capabilities*:
   - Code leader who can double as a recorder and secure Intra Osseous access if needed.
   - Crash cart nurse who can double as medication and defibrillator administrator and secure IV access if needed.
   - A respiratory therapist to manage the airway including use HEPA filter with Bag Mask Ventilation and administration of meds via the ET tube if needed.
   - Two individuals to maintain effective chest compressions unless a Lucas device or other automated chest compression system is available.
   - Other considerations: No policy dealing with an issue this complicated can anticipate every clinical situation. *Each facility* will need a process to define personnel for 1 – 4 above, recording, crash cart ingress/egress (including decontamination post CPR), access to PPE, and access to additional medications.

3. CPR should not be attempted if in the reasonable judgment of the physician it will not lead to survival (for example MOSF or widely metastatic cancer) in a PUI or patient confirmed with COVID-19.
4. CPR should not be attempted on a PUI or patient confirmed with COVID-19 in the absence of PPE.
5. As outlined in the Ethical Guidance section above, DNAR validation rules under Texas law do not apply in the ED but do apply once a patient is admitted to the hospital. These validation rules should be followed to the best of the professional’s ability, recognizing that in overwhelming circumstances, time demands may leave only validation method 8 reasonably available.
6. Each hospital leadership team is responsible for specifying personnel, supplying equipment, and adapting this policy to local circumstances, including proactive resource and personnel planning to:
    - Access and introduce emergency equipment into isolation rooms as well as disposal or decontamination of equipment post procedure.
    - Access additional emergent medications (paralytics, insulin, etc.) as needed.
    - Determine appropriate personnel roles for implementation of CPR in this setting.

ATTACHMENTS

None.

RELATED DOCUMENTS

Attempted Cardiopulmonary Resuscitation (“CPR”) (BSWH.CLNETH.005.P)
COVID-19: Interim Infection Prevention and Control Recommendations (BSWH.CLN.110.G)

REFERENCES

None.