Lippincott DocuCare

Student name: Caeli Edwards 4/21/21

Title of Student Activity

Think – it – Through
MHRSON Modified Blue Box Form

Estimated Time: 1 hour

Description of Activity:
This activity is designed to enhance your understanding of not only end-of-life care, but also the case management role in preparation for optimal home care post discharge with available resources assessed and in place prior to the client's release from the acute care facility.

Student Learning Outcomes

1. Identify focused information related to the diagnosis of advanced lung cancer.
2. Determine potential nursing diagnoses for a patient with advanced lung cancer.

Assignment

1. Review lung cancer prior to accessing the patient chart.
2. Complete the focused Blue Box Form on the next page.
3. List 2 potential patient problems (NDx) in the bottom section of the blue box form.
4. Once the above are completed, access Julia Morales' patient chart under the DocuCare Assignment section for completion of the remaining active learning templates.
5. Submit the entire student packet, including all of the following forms & templates plus your reflection paper on a separate document via Edvance360 dropbox by 1600 on the date the assignment is due.

Anecdotal Criteria

The "Think-it-Through" activity and forms will be reflected on the anecdotal in the following areas:

1. Pathophysiology
2. Diagnostic studies
3. Treatment measures
4. Identifying patient problems
5. Planning & implementing
6. Patient teaching
7. Dependability

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation

NCLEX IV *(7)*: Reduction of Risk

Prognosis for clients with lung cancer	Symptoms often experienced with advanced lung cancer	Diagnostics to determine extent of disease process
-second most common type of cancer in the US -leading cause of cancer related deaths -60% 5 year survival rate -specific prognosis depends on the stage of the cancer (localized, regional, distant) – depends on how early the cancer was found and treatment began -236,000 predicted diagnosis in 2021	-coughing up phlem or blood -persistant cough -SOB -weakness/fatigue -as the cacer spreads symptoms will depend on other tissue/organ involvement: -lymph node involvement: lumps in neck/collar bone -bones: pain in back, hips or ribs -brain or spine: HA, dizziness, unbalanced, numbness in extremities -liver: jaundice	-biopsy is the definitive dx -bronchoscopy -MRI/CT scan -CXR -PET scan -sputum samples -PFT

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Anticipated Medication Management
-Chemotherapy / radiation -Opiods for pain management -Antiemetics -immunotherapy drugs

NCLEX IV *(5)*: Basic Care and Comfort

Non-Pharmacologic Care Measures
-distraction techniques for pain -frequent rest periods -oral care - IS/ deep breathing techniques

Client/Family Education

List 3 potential teaching topics/areas
• coping mechanisms/ support groups •non-pharm pain erlief techniques •importance of frequent rest periods

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement (Which other disciplines do you expect to share in the care of this patient)
-PT/OT -Oncologist -Pulmonologist - Nutrition -Home health -Palliative care / Hospice

ID Patient Problem

List 2 potential nursing diagnoses (do not include R/T or AEB)
-Impaired gas exchange -Acute and/or chronic pain

5 “What’s”

Estimated Time: 1 hour

Description of Activity:
This activity builds critical thinking and clinical judgement by encouraging students to ask the question “what” when planning and implementing interventions for a terminally ill patient.

Student Learning Outcomes

1. Explain the difference between hospice care and palliative care.
2. Identify components of hospice care and services provided.
3. Research DMOST and Beebe Healthcare’s Palliative Care policy (attached).
4. Explore the provision of care for the terminally ill older adult in the home setting.

Assignment

1. Research hospice care and DMOST. Review Beebe’s Palliave Care policy (attached).
2. Fill out the data in the next worksheet using critical thinking and information obtained from research. You do not have to be lengthy, it is better to simply explain the concepts in your own words.
3. Log onto thePoint and launch Lippincott DocuCare. Access “Julia Morales” under the assignment section.
4. Open Julia Morales’ EMR and review the following to gain insight into your assigned patient:
    - Patient Information
    - Notes
    - Physical Assessment Documentation
    - Vital Signs
    - Diagnostics
    - Morse Fall Risk Score
    - Activity of Daily Living Assessments

Anecdotal Criteria

The “5 Whats” activity and form will be reflected on the anecdotal in the following areas:

1. Diagnostic studies
2. Treatment measures
3. Planning & implementing
4. Resources
5. Ethical, legal
6. Dependability

5 “What’s” Worksheet

What…	
Data	**Answer**
What is the difference between hospice care and palliative care?	-Pts must meet certain criteria in order to qualify for hospice care, where as palliative care pts don’t have to meet the same requirements -Hospice entails a prognosis of 6 months or less, whereas palliative care can be utilized during any stage of the disease -hospice care excludes curative treatment, where palliative care may or may not include some curative treatments but both focus on the comfort of the client -hospice care cannot be utilized while curative treatment is taking place, but palliative care can be.

What…	
Data	**Answer**
What diagnostic criteria is needed for entry into hospice? (research required)	-in order to qualify for hospice care the patient must have a prognosis of 6 months or less, verified by two physicians -Pt cannot be undergoing curative treatment during hospice care, only pain and comfrt measures.

What…	
Data	**Answer**
What services can hospice provide? (research required)	-primary care that does not include curative treatment measures. -focuses on comfort, emotional and spiritual needs of the patient -symptom management -Chaplains or other spiritual needs of the pt -pt and family support

What…	
Data	**Answer**
What is DMOST? (research required)	- Delaware Medical Orders for Scope of Treatment -addresses a persons preference on end of life care, similar to an advanced directive -used in conjuction with advanced directives -only used when pt is expected to live for another year or less -addresses patients specific condition and reflects their preferences for treatment

What…	
Data	**Answer**
What role does the hospital play in preparing to discharge a terminal patient to home care? (critical thinking)	-it is important to discuss what the patients preferences are for their treatment and what they expect with their end of life care. -Give information regarding DMOST/ advanced directives -Hospice/home care -Provide emotional support to both the patient and their family

Title of Student Activity

Care Management- Can I Get a Resource?

Estimated Time: 1 hour

Description of Activity:
Ms. Morales has made the decision to forgo further treatment. This activity asks students to assume the case management role and use assessment findings to determine appropriate resources for transitioning to home care.

Student Learning Outcomes

1. Identify common problems in older adults or terminally ill that warrant further investigation using the Katz Index of Independence in Activities of Daily Living (ADL).
2. Analyze the tool results and determine what the results mean in planning for home care.

Assignment

1. In this component, you are the Case Manager for Julia. Morales.
2. Ms. Morales was seen 30 minutes after you opened her chart by Social Services and OT. Review their notes in notes section, social services section, OT section, and ADL assessment.
3. Ms. Morales's partner has left to make arrangements at home and Ms. Morales is sleeping. When time is of the essence, case managers frequently have to resort to making determinations from what is charted in the EMR. At this point, you only have the chart to use in completing your assessment.
4. Complete the following two worksheets using info obtained from Julia Morales' updated EMR in DocuCare.

Anecdotal Criteria

The "Case Management – Can I Get a Resource" activity and forms will be reflected on the anecdotal in the following areas:

1. Assessment
2. Procedures
3. Safety
4. Resources
5. Dependability

Title of Worksheet

Can I Get a Resource? Worksheet

Katz Index of Independence in Activities of Daily Living			
DATA	**Independence (1 point)** **No** supervision, direction or personal assistance.	**Dependent (0 points)** **With** supervision, direction, personal assistance or total care.	**DocuCare Findings**
BATHING: Points: ____0_____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing	Total dependence
DRESSING: Points: ____0_____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.	Extensive assistance
TOILETING: Points: ____0_____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self, or uses bedpan or commode.	Supervision needed
TRANSFERRING: Points: ____0_____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.	Total dependence – 2 person assist at bedside
CONTINENCE: Points: ____1_____	(1 POINT) Exercises complete self-control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel of bladder.	Continent – requires assistance to transfer to BR
FEEDING: Points: ____1_____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.	Independent
CALCULATE TOTAL POINTS:____2____ **SCORING**: 6 = High (Patient Independent) 0 = Low (patient very dependent)			

After Completing the Katz Index of Independence in Activities of Daily Living (ADL) Assessment, what do the results mean to you as you begin planning this patient's home care?

This patient requires a lot of dependence with transferring and other ADL's. While planning care this means that time needs to be set aside to assist the patient and ensure patient is turning in bed. Home care will be necessary once patient is discharged. OT and PT would be helpful resources with this patient.

Title of Student Activity

Care Management - Let's PREPARE!

Estimated Time: 1 hour 30 minutes

Description of Activity:

This activity asks students to assume the case management role and use assessment findings to determine appropriate resources for Julia Morales.

Student Learning Outcomes

1. Assess caregiver preparedness using the Informal Caregivers of Older Adults at Home: Lets PREPARE! Assessment tool.
2. Identify nursing interventions related to Let's PREPARE! Assessment tool findings.

Assignment

1. Continuing in your case management role, complete the "Let's PREPARE" worksheet. If the information is not available or not provided, state as such.
2. Determine needed revisions and individualization to your original nursing diagnoses for a patient with advanced lung cancer.
3. Complete PIE notes as directed at the end of the "Let's PREPARE" worksheet. Use the modified PIE notes form that is provided on the page following the worksheet.
4. After writing your PIE notes, revise or update your patient problem. Properly label each PIE note entry with the corresponding patient problem identification.
5. Determine appropriate goals for each patient problem, and indicate if you felt the EO would have been met or not met.

Anecdotal Criteria

The "Let's PREPARE" activity will be reflected on the anecdotal in the following areas:

1. Procedures
2. Assessment
3. Planning & implementing
4. Evaluates nursing process
5. Documentation
6. Communication
7. Patient teaching plan
8. Resources
9. Collaboration with staff
10. Dependability

Care Management - Let's PREPARE! Worksheet

Informal Caregivers of Older Adults at Home: Let's PREPARE!	
DATA **Use this standardized assessment tool to obtain information for preparing for transition to home care. Utilize the patient's electronic health record to assist with data collection related to the Let's PREPARE! Assessment tool.**	**ANSWER**
Prescriptions: • **Pharmacy Location** • **Delivery or Pick-up at Pharmacy**	-Utilizes Rite Aid Pharmacy -2 miles from home -Able to utilize drive up window
Readiness to Manage at Home: • **Home care needs for the older adult** • **Contact numbers of home care staff, primary care provider, hospital, support system** • **Insurance** • **Supplies** • **Modifications to home to prevent falls and injury**	-no medical equipment at home -needs assistance for ADL's – high fall risk -Has support of partner and son at home -PT/OT/ home health aid recommended at home for safety
Early Changes in Condition: • **Knowledge of changes requiring urgent medical professional notification**	-recent weight loss without intention -pain unrelieved by medication
Partnership among the Home Health Care Team: • **Supplies** • **Equipment** • **Durable Medical Equipment** • **Activities of Daily Living**	-home health will need to evaluate the home and situation to determine what equipment will be necessary -gait belt, hospital bed, bedside commode, personal hygiene supplies -PCA medication equipment required -Total assistance with ADL's.

Assistance needed to perform procedures: • **Wounds** • **Intravenous Treatment** • **Suctioning** • **Activities of Daily Living**	-PCA pain medication – IV at home -Total assistance with transferring, bathing, dressing, toileting
Realistic Expectations and Goals: • **What does the older adult want to achieve?** • **Is care Palliative?** • **Does the informal caregiver have other family responsibilities?** • **Is the informal caregiver employed?** • **Does the informal caregiver live with the older adult?** • **Does the informal caregiver have a back-up support?**	-Wants to be out of the hospital (doesn't want to die in the hospital) -Comfort care and pain management -Does the informal caregiver (Lucy – partner) live with the older adult? Yes – retired – no other responsibilities. -Does the informal caregiver have a back-up support? – son - Neil
Education and Empowerment: • **Long-term care plan** • **Nutrition** • **Advanced Directives** • **Safety in Home** • **Problems with medications** • **Contingency Plan if home care aide does not arrive**	-care plan: withdrawl curative treatments, manage pain, comfort care at home -nutrition: as tolerated – encourage foods the pt enjoys, small frequent meals -Advanced directives: DNR/DNI -Medications: pain unrelieved by pain medication – PCA pump to be inititated -Assistance from partner and son as needed
Follow-Up Nursing Interventions needed: -Provide emotional support to patient and family -Instuctions on medications, ADL's and what to expect -Education on role of home health aid and what to expect -Education and support about hospice care -Advoate for patient	
PIE Charting: After reviewing the above data, the ADL assessment in DocuCare, and the KATZ ADL assessment tool findings, document a PIE note for Julia Morales on the PIE note form on the next page. After PIE notes are written, list the patient problems you feel are pertinent to your patient (anticipate possible revisions or changes to the original NDx you wrote). Next, identify each PIE note entry with the corresponding patient problem identification. Notes are to include any nursing interventions you would have implemented (use critical thinking) and the desired patient response (i.e. evaluation) if you had actually cared for Ms. Morales. As this is a virtual learning experience, notes will be based on what you think would have transpired. Include in your notes an assessment of the situation and what will be needed to provide care in the home, such as services, equipment, and training for the caregiver.	

Nursing Notes

I Or E	Notes	Specify Problem #
E	65-year-old female with a four-year history of adenocarcinoma of the lung. Previous treatment of chemo, radiation and immunotherapy were stopped yesterday. Constant pain 9/10 stabbing/piercing/crushing in back and abdomen. Pain uncontrolled by medication. BP: 90/60, HR 88, RR 24. Fatigued and weakness. Required maxium assistance with ADL's.	1, 2
I	Referral to home health and hospice with PCA pain medication. PT/ OT referral.	1, 2
E	Assist x2 for transfers, only steady at bedside for a short period of time.	2
I	Assist using gait belt and walker to bedside commode or BR. Encourage meals to be eaten in chair.	2
E	Pain 9/10 in back/ abdomen.	1
I	Administered morphine, provided a low stimulus environment, educated on distraction techniques such as meditation.	1
E	Pain 4/10. Pt states the distraction techniques along with medication helped to relieve some of the pain.	1
E	Pt states there is no medical equipment at home, able to receive medications from Rite Aid pharmacy using drive-thru. Assistance at home by partner and son when needed.	2
I	Contacted home health agency to provide patient report, advocated that medical supplies such as bed and walker and PCA pump may be needed. Encouraged a home health evaluation upon discharge. Educated pt on use of PCA pump.	1, 2
I	Stated she wanted to get out of bed to eat her lunch.	2
E	JM eating lunch in chair, states pain is 4/10 in back/abdomen.	1, 2

Patient Problems & Goals

Problem #1: Chronic Pain

Patient Goals:

1. JM will rate pain 6/10 or less during my time of care _____ Met ☒ Unmet ☐
2. JM will verbalize pain relief methods that work during my time of care. _____ Met ☒ Unmet ☐

Problem #2: Impaired physical mobility

Patient Goals:

1. JM will transfer from bed to BR with assist x2 during my time of care _____ Met ☒ Unmet ☐
2. JM will transfer to chair for all meals with the assist x2 during my time of care _____ Met ☒ Unmet ☐

Pharm 4 Fun - Medication Prep & Patient Education

Estimated Time: 1 hour

Description of Activity:
This activity requires the student to research a medication using appropriate pharmacology resources along with an exercise in medication calculations, preparation, and teaching.

Student Learning Outcomes

1. Explain purpose for taking morphine, an opioid narcotic, for pain management.
2. Discuss pertinent patient education related to PCA morphine administration for pain management.

Assignment

1. The primary healthcare provider saw Julia Morales 1 hour after you originally opened her chart, and wrote new orders for pain management.
2. Locate and open Julia Morales' EMR.
3. Review updated medication orders.
4. Use the smart sense link in DocuCare (green stethoscope beside the medication) to complete the "side effects" and "patient education" worksheet on the next page.

Anecdotal Criteria

The “Pharm 4 Fun” activity and forms will be reflected on the anecdotal in the following areas:

1. Treatment measures
2. Pharmacologic therapies
3. Patient teaching
4. Dependability

Lippincott DocuCare

Title of Worksheet

Pharm 4 Fun – Medication Prep & Patient Education

Name of Medication, Classification, and Prototype	
Data	**Answer**
Medication:	**Morphine PCA**
Classification:	**Opioid Analgesic**

Ordered Dose, Time and Route	
Data	**Verify new order:**
Morphine ***Morphine via a PCA has been ordered to control the patient's excessive pain. The PCA allows the patient to self-administer small, prescribed doses of an opioid analgesic. The patient doesn't have to rely on the nurse to obtain the medication and administer it. It is delivered through the patient's IV when the patient presses the PCA button.***	**1mg/1mL Concentration for use in a PCA. On demand dosing of 2mg to be administered when patient pushes PCA button. Timing is on demand with Lock out set at 10 minutes and 1-hour maximum amount of 12mg. The medication is administered through the patient's IV.**

What are the side effects the nurse needs to be alert to when this medication is being administered?
Answer
Respiratory depression, dizziness, drowsiness, seizures, HTN, constipation, diaphoresis, nausea, urine retention. Always assess RR – administer PRN antiemetic first if available

Patient Education While Taking this Medication
Answer
Educate on possible side effects, caution when transferring once medication is initiated – dizziness could cause falls. Nausea may occur – small bites of food / antiemetics. Operation on the PCA pump – educate how the pump works and that it locks out after a certain amount of medication is administered to prevent overdose of the medication. Educate patient and family that only the patient themselves should be hitting the button, not family.

Medication calculation	
	Answer
Julia is continuing to experience breakthrough pain, and the primary healthcare provider has ordered Morphine 8mg IV push stat. Morphine is supplied as 10mg/ml. How many milliliters will you draw up to administer the ordered dose?	$8\text{mg} \quad \frac{1\text{ ml}}{10\text{ mg}} \quad = 0.8\text{ ml}$

Hold curser on red line and move the line to the correct positon on the syringe to administer the ordered dose of morphine.

SBAR Worksheet for Interagency transfer

Estimated Time: 30 minutes

Description of Activity:
This SBAR activity assists you in building the skill of communicating pertinent information when caring for a patient. Appropriate actions you should do to complete this activity including finding necessary data to provide a thorough SBAR report. You are preparing this report for the home health nurse.

Student Learning Outcomes

1. Identify pertinent data in a patient's electronic health record (EHR).
2. Communicate pertinent information for a patient using SBAR communication.

Assignment

1. Julia Morales is now being discharged to home. For this exercise, you are her primary nurse, and are calling the home health nurse to give her a report as the patient is being released.
2. Complete the SBAR worksheet on the next page.

Anecdotal Criteria

The "SBAR" activity and forms will be reflected on the anecdotal in the following areas:

1. Communication with healthcare team members
2. Collaboration with staff
3. Dependability

SBAR Worksheet for Interagency transfer

Situation	
Data	**Answer**
Patient's name, age, specific reason for transfer	Julia Morales 65 year old female admitted for unrelieved back and abdominal pain related to current diagnosis of lung cancer. Recent unintentional weight loss.

Background	
Data	**Answer**
Patient's primary diagnosis, support personnel, and current orders for patient that need to be relayed to hospice.	Diagnosis of Stage 4 Adenocarcinoma of the lungs – stopped curative treatment yesterday with oncologist. Her partner (Lucy) is her support person, along with her son, Neil. Pt does not want to remain in hospital – home health referall has been initited. Currently on 2L O2 NC. Diet is as tolerated, typically only about 25 % of meals. Receiving Docusate Calcium 100 mg PO Q24 PRN, Morphine Hydrochloride 100 mg PO Q6hr PRN, and Morphine Hydrochloride 1mg/1ml concentration for PCA with on demand dose 2 mg with 8 minute lockout and maximum 1 hr dose of 12 mg – PCA is new and pt has received education on use of the pump.

Assessment	
Data	**Answer**
Current pertinent assessment data regarding patient's functional ability and needs for care in the home	Requires maximum assistance (x2) for bathing, dressing, and toileting. Tranfer is max assist x2 with gait belt and rolling walker. Continent of bowel and bladder but requires assistance to BR or bedside commode. Able to feed self. Weak and unsteady. Only able to stand at bed side for a short period of time.

Recommendation	
Data	**Answer**
Any orders, interventions, or treatments, or recommendations you may have for this patient	Further education on PCA pump and non pharmacological pain relief techniques. Frequent reevaluation of pain and evaluation for PRN pain medications for breakthrough pain. Further education and expectations for home health. Provide continuous emothion support for patient and family.

Discussion Post

Estimated Time: 30 minutes

Your patient elected to stop all treatments. When is it an appropriate time for this decision to be made? Should you accept the patient's decision without question or are there questions you should ask to ensure your patient completely understands the implications of her decision? Write your thoughts on the discussion board on Edvance 360.

Reflection Paper

Estimated Time: 1 hour

Please submit your reflection paper as a separate document. Be sure to refer to the checklist regarding proper formatting, i.e. font, spacing, etc.

A. **Describe an "A-ha" moment you experienced during this virtual clinical simulation and how it will affect your nursing practice.**

B. **Beebe Healthcare recently updated their code policy (see attached). What are your thoughts concerning the new designations? Do you feel the designations are clear or do you feel the new policy is either not needed or too confusing? How would explain the policy to your patient to make her aware of all options? How does this policy compare to the care given to Julia Morales? Are there areas for improvement in this policy? Does the policy incorporate aspects of care that were not evident in the simulation? Why is this policy important and how does it impact nursing?**

Beebe Healthcare

Patient Care Manual

DECISION TO LIMIT, WITHHOLD OR WITHDRAW LIFE SUSTAINING TREATMENT (To include, but not limited to, Do Not Attempt Resuscitation/No Cardiopulmonary Resuscitation (DNAR/No CPR) Orders)	Date issued: 4/2001
Issued by: Bioethics Committee Approved by: Dr. Ercilia Arias, Medical Director of Intensive Care Unit, Steven Rhone, Chief Nursing Officer and the Medical Executive Committee	Revised: 12/6/01, 1/02, 1/06, 3/11, 12/13, 9/19
[ ] Condition of Participation [ ] Joint Commission Standard [ ] Department Specific Regulation	Reviewed: 11/07

PURPOSE

Beebe Healthcare is committed to preserving life and limiting pain and suffering. We recognize the patient's (or if the patient lacks decision-making capacity, his or her legal representative's) right to participate in and make decisions about treatment. They will be provided with adequate information regarding treatment options to include limiting, withholding and withdrawing treatment (including resuscitation).

Care necessary to meet emotional, spiritual and comfort needs including adequate pain relief, are to be provided without regard to decisions to limit, withhold or withdraw treatment. This policy identifies and describes the responsibilities and procedures for making and implementing decisions to limit treatment, withhold treatment (including resuscitation), withdrawal treatment and the process for resolving conflicts.

An adult individual who has decision-making capacity has the right to plan ahead for health care decisions through an Advance Health care Directive, and/or through a DMOST (Delaware Medical Orders for Scope of Treatment) and to have the wishes expressed in those documents respected, in order to ensure that the right to control decisions about one's own health care is not lost if a patient loses decision-making capacity and is not able to participate actively in making his or her own decisions, either temporarily or permanently.

SCOPE

This policy applies to all of Beebe Healthcare.

DEFINITIONS

ACLS (Advanced Cardiac Life Support): a set of clinical algorithms for the urgent treatment of cardiac arrest, stroke, myocardial infarction and other life-threatening cardiovascular emergencies.

Advance Directive: Individual Instruction (formerly Living Will) or Power of Attorney for Health Care or both. An Advance Directive is a direction from the patient, not a medical order.

Capacity: an individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision.

Code Status Options: The following are the code status options at Beebe Healthcare:

- "Full Code"
- "DNAR/No CPR"
- "DNAR/AND"

Full Code: Patients are assumed to be "Full Code" unless placed in the other code classification by means of the procedure outlined within this policy. Full Code patients are to receive all resuscitative efforts to reduce mortality and morbidity. These measures may include, but are not limited to:

- Closed or open chest cardiac compression
- External or internal electrical cardiac defibrillation and pacing
- Tracheal Intubation
- Mechanical Ventilation
- Medication Administration (ACLS Medications)

DNAR/No CPR (Do Not Attempt Resuscitation/No Cardiopulmonary Resuscitation): In the event of a cardiac or pulmonary arrest, no cardiopulmonary resuscitative measures will be initiated, inclusive of mechanical, electrical or chemical measures.

DNAR/AND (Do Not Attempt Resuscitation/Allow Natural Death) (previously termed "comfort measures"): Medical care focused on relieving symptoms and optimizing patient comfort. Comfort care does not seek to cure or aggressively treat illness or disease.

For both DNAR/No CPR and DNAR/AND, at the time of arrest, dying is permitted to progress naturally:

1. "Code Blue" is not activated
2. CPR, mechanical ventilation or tracheal intubation are not performed
3. Ventricular defibrillation is not performed
4. No medications are administered (except for comfort—see below)
5. No intravenous access is attempted unless needed for comfort medications

DNAR/No CPR and DNAR/AND code status may include/permit, but may not be limited to, medical support to keep the patient comfortable, such as:

1. Suctioning of the airway
2. Administration of oxygen and pain medication
3. Positioning for comfort
4. Controlling bleeding
5. Appropriate therapies

DNAR/No CPR status does not determine unit assignment or level of care a patient receives prior to an arrest.

Guardian: a judicially-appointed adult having authority to make health care decisions for an individual (there will be a Court Order in existence that documents this). Once the Court has legally appointed a Guardian for the patient, the patient can no longer have the legal ability to make health care decisions, including appointing someone as his or her agent. The Guardian is the only one who has that ability going forward. However, any Advance Directives implemented prior to the appointment of the Guardian must be followed.

Health care Practitioner or Provider: a physician or individual licensed and authorized to write medical orders who is providing care for the patient or overseeing the health care provided to the patient and has completed all training required by the Delaware Department of Health and Social Services for individuals participating in the completion of a DMOST form.

Individual Instruction: means an individual's direction in writing concerning a health care decision for the individual (e.g. written End of Life Instructions)

Life-sustaining procedure: means:

(1) An medical procedure, treatment or intervention that:
    a. Utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function and
    b. Is of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition or permanent unconsciousness
(2) Procedures which can include, but are not limited to the following: assisted ventilation; renal dialysis; surgical procedures; blood transfusions; administration of drugs, antibiotics and artificial nutrition and hydration.

Nothing above within the definition of Life-sustaining procedure is meant to limit or curtail treatment provided for comfort or palliative measures.

DMOST (Delaware Medical Orders for Scope of Treatment): a portable medical order recorded on a standardized form. The information on the form records the outcome of a conversation between the patient and a practitioner who has been caring for the patient. The form documents the patient's desired goals of care and notes medical orders describing the use of or withholding of life sustaining treatments for patients who are in a Qualifying Condition. The DMOST is neither an Advance Directive nor a replacement for Advance Directives; both are helpful advance care planning documents.

Power of Attorney for Health Care: means the designation of an agent to make health care decisions for the patient who grants them the power to do so. Note: a Power of Attorney for Health Care is different than a Durable Power of Attorney. A Power of Attorney for Health Care relates to health care decisions, while a Durable Power of Attorney relates to financial matters.

Qualifying Condition: means the existence of one or more of the following three (3) conditions, in the patient, certified in writing in the patient's medical record by the attending physician AND by at least one other physician who, when the condition in question is "permanently unconscious" shall be a board-certified neurologist and/or neurosurgeon:

a. Permanently Unconscious: a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable certainty is a total and irreversible loss of consciousness and capacity for interaction with the environment; the term includes a persistent vegetative state or irreversible coma.
b. Terminal Condition: means any disease, illness, or condition sustained by the patient for which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of the patient regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life and the life processes.
c. Serious Illness or Frailty: means a condition based on which the health care practitioner would not be surprised if the patient died within the next year.

Therefore,

If a patient lacks capacity and is NOT (1) in a terminal condition, or (2) a permanently unconscious state or (3) with serious illness or frailty, the agent may make all health care decisions for the patient EXCEPT for decisions to provide, withhold or withdraw a life sustaining procedure (and as long as the patient did not limit the agent's authority, such as in a previously executed Advance Directive or DMOST). The agent may consent or refuse any care treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition (unless it is a life-sustaining procedure or otherwise required by law). An agent can also select or discharge health care providers and health care institutions.

However,

If a patient lacks capacity and IS in (1) a terminal condition, or (2) a permanently unconscious state, or (3) with serious illness or frailty, the patient's agent may make ALL health care decisions for the patient, INCLUDING consent for or refusal of life-sustaining procedures such as cardiopulmonary resuscitation. The agent can also direct the providing, withholding or withdrawing of artificial nutrition, hydration, and all other forms of health care. Of course, this is as long as the patient did not limit the agent's authority to do so in a previously executed Advance Directive or DMOST.

Reasonably available: means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs.

Surrogate: an adult individual who: (1) has capacity; (2) is reasonably available; (3) is willing to make health care decisions to initiate, refuse to initiate, continue or discontinue the use of life- sustaining procedure on behalf of a patient who lacks capacity; and (4) is identified by the attending physician in accordance with this Policy.

- If the patient has no Guardian and has not already designated an Agent in writing (e.g. Power of Attorney for Health Care) or a pre-chosen Surrogate verbally (with requisite witnesses documented in the Medical Record), then a Surrogate may make health care decisions for the patient without capacity.
  For information on who can act as the patient's Surrogate in the absence of a Guardian, or an already-designated Agent or Surrogate, please see policy: "Surrogates, Agents, and Guardians in Health care Decisions" in the Patient Care Manual

TREATMENT

LIMITATIONS

A. Discussion of Treatment Limitations

Discussion regarding Limiting Treatment is appropriate, but not limited to the following:
The patient has:

a. Upon assessment of the patient seeking medical treatment
b. Legal representative (Guardian, Agent or Surrogate) requests to limit treatment or no resuscitation

The patient's Health care Practitioner facilitates communication between the patient (or legal representative if the patient does not have capacity) if the patient is living with a Terminal Condition, is Permanently Unconscious or has Serious Illness or Frailty. The discussion would include the patient's goals, what medical treatment the patient would

want and not want.

The patient initiates a request to limit treatment or not to be resuscitated. An adult individual who has decision-making capacity has the right to refuse medical or surgical treatment in order to allow natural death if such refusal is not contrary to existing public health laws.

Specific to Pregnant Patients: orders to limit, withhold or withdraw life-sustaining treatment cannot be written for pregnant patients as long as it is probable that the fetus has the potential to be viable outside of the uterus.

The physician or healthcare practitioner will have a full and sufficient discussion with the patient or legal representative concerning the nature of the illness, the prognosis, the options for treatment including palliative/supportive care and recommendations regarding treatment limitations. The physician is responsible for documenting any and all conversations with patient, family or legal representative and their understanding.

B. Documentation of Treatment Limitations

The health care practitioner will complete the DNAR/No CPR or DNAR/AND Order in the EMR (or on the paper order sheets in the chart in the event of downtime) the health care practitioner will use the following to determine the appropriate order:

- The patient's current medical condition and prognosis
- Statement of the patient's decision-making capacity
- Discussion between the physician and the patient or legal representative
- In following the patient's Individual Instruction, or the wishes of the patient's legal representative (if there is no Individual Instruction) the patient is certified to be in a Qualifying Condition (see definitions above) that is documented in writing by two physicians. If the Qualifying Condition is "Permanently Unconscious," the 2nd physician shall be a board-certified neurologist and/or neurosurgeon.

C. Documentation of the Rationale for the Treatment Limitations

Documentation of the discussions and rationale for the Order entered is required. Include the following in the Note:

- The patient's current medical condition and prognosis.
- Statement of the patient's decision-making capacity.
- Discussion between the physician and the patient or legal representative
- In following the patient's Individual Instruction, or the wishes of the patient's legal representative (if there is no Individual Instruction) the patient is certified to be in a Qualifying Condition (see definitions above) that is documented in writing by two physicians. If the Qualifying Condition is "Permanently Unconscious," the 2nd physician shall be a board-certified neurologist and/or neurosurgeon.

D. Communication of Treatment Limitations

The healthcare provider will place the order to limit treatment AND communicate to the nurse caring for the patient that there was an order placed. The nurse caring for the patient is responsible for communication to other members of the treatment team that a DNAR/No CPR or DNAR/AND order has been entered to limit treatment. If using the paper orders of the medical chart in the case of downtime, the DNAR/No CPR or DNAR/AND order will be placed at the front of the Physician Orders Section of the medical record.

- Telephone Treatment Limitations (DNAR/No CPR or DNAR/AND) Orders to nursing staff are highly discouraged; however,

- In extreme circumstances, IF the healthcare provider had previous discussion with the patient and/or legal representative, the nurse will receive the telephone order for Treatment Limitations (DNAR/No CPR or DNAR/AND) and document such in the medical record. The physician must sign the order within 24 hours and document discussion with patient/legal representative.

- Identification of Patients with Treatment Limitation Orders.
  - The nurse will place a purple wristband/bracelet on the patient's wrist indicating resuscitation status (see limited exceptions below for Gull House and Tunnell Cancer Center ("TCC") Radiation Oncology).
  - The resuscitation status will be noted in the Electronic Medical Record "Banner Bar." If not using an EMR, then information identifying the patient as DNAR/No CPR or DNAR/AND is to be noted on the outside of the patient's hard copy medical record (e.g. Gull House).

E. For the Operating Room or Invasive Procedures:

Patients are permitted to have surgery or invasive procedures with a code status of DNAR/No CPR or DNAR/AND order. This decision will be honored. The physician performing the procedure and/or anesthesiologist will review treatment limitations and/or any existing DNAR/No CPR or DNAR/AND order with the patient or legal representative prior to the operative procedure. If the patient decides to maintain code status, and if the surgeon or anesthesiologist does not agree, the care of the patient shall be transferred to another physician who will agree to honor this decision as per the Medical Staff Bylaws.

If the patient agrees to change their code status for the duration of the operative procedure, follow the process below:

1. The physician performing the procedure and/or anesthesiologist will document the discussion and any changes applicable only to the operating room.

2. Post procedure or upon arrival to the floor/unit, the DNAR/No CPR order will be resumed by the person performing the procedure (the person that temporarily amended the resuscitation status is the one to re-institute the order).

REVOCATION or REVISION of TREATMENT LIMITATION ORDERS

A. Documentation of Revocation:

1. The physician will:
   a. Document the discussion between the physician and the patient or legal representative in the progress note.
   b. Enter an order to discontinue the DNAR/No CPR or DNAR/AND Order, or

2. The nurse will:
   a. Enter a Telephone order to discontinue the DNAR/No CPR or DNAR/AND Order into the EMR (if using downtime procedures, a new order sheet must be created and placed at the front of the physician order section).
   b. Remove the purple wristband/bracelet from the patient's wrist

► Once revoked, Limitations of Treatment may be re-instituted by the procedure outlined in this policy.

B. Documentation of Revision (requires new DNAR/No CPR or DNAR/AND Order):

1. The responsible physician will:
   a. Document the discussion between the physician and the patient or legal representative in a progress note.
   b. Enter an order to discontinue the DNAR/No CPR or DNAR/AND Order.
   c. Complete a new DNAR/No CPR or DNAR/AND Order in the according to the procedure outlined in this policy.

2. The nurse will:
   a. Transcribe the discontinued order in the paper order section in the event of downtime according to the procedure outlined in this policy
   b. Communicate revision of the DNAR/No CPR or DNAR/AND Order to other members of the treatment team.
   c. Remove the purple wristband/bracelet from the patient's wrist, if appropriate.

Specific tp Tunnel Cancer Center ("TCC"):

A. Radiation Oncology:

Upon Registration the patient will be asked if he or she has a DMOST. If the DMOST orders that the patient does not want to be resuscitated (DNAR/No CPR), then a purple sticker will be applied to front of the hard-copy chart. In addition, an Icon in the EMR will be noted (purple bow) to show that the patient is not to be resuscitated.

During the patient's course of treatment, the patient will be asked if there were any changes or updates to the DMOST order. If there are changes, then the order in the EMR will be updated accordingly and the purple sticker and icon will change if applicable.

B. Medical Oncology:

Information specific to TCC for Advance Health care Directives and DMOST orders:

1) Identification of patients with Treatment Limitation orders at TCC.
   - Upon arrival to TCC, the registrar will ask each new patient if s/he has an Advance Health care Directive and/or a DMOST order. Responses are noted in the patients' medical record.
   - Goals of care to be discussed at each physician visit or infusion treatment appointment. If the DMOST orders DNAR/No CPR or the patient requests to be DNAR/No CPR, the order will be initiated during the patient's trajectory of care.

2.) Documentation of Treatment Limitation orders at TCC.
   - If patient answers YES, a copy is requested for the medical record and the appropriate notation will be made in the Demographics section in Varian (Oncology EHR).
   - If the patient has the copy with them, the Registrar will scan the document into Document Imaging as well as the "NOTE" section of Varian. The appropriate notation will be made in the Demographic section.
   - If the patient does not have a copy with them, it is noted in the Demographics section that a document exists. They are to be asked by a provider what their resuscitation status is on their document and it is recorded appropriate. Then the patient is requested to bring in a copy to be placed in their medical record. Once the document is received, A copy of the document will be scanned into Document Imaging as well as the "NOTE" section of Varian. The appropriate notation will be made in the Demographic section in Varian (Oncology EHR).

- If the patient answers NO, the appropriate notation will be made in the Demographic section in Varian (Oncology EHR). The patient will be offered information about Advance Health care Directives and/or DMOST order plus referred to the social worker
- If patient requests assistance regarding either type of document, the registrar will send a reminder to the social worker to schedule a time to meet with the patient and/or family.

3.) Communication of Treatment Limitation orders at TCC. (Medical Oncology and Infusion)

- Use of high priority comment and patient status icon to be placed on the face sheet of patient's EMR.
- The following patient status icons will be used to alert staff:
- A "purple bow" icon will be used to indicate that patient has a DNAR/No CPR order on file.
- A "red and black AD" will be used to indicate that patient has an Advance Directive for Health care on file.
- If the patient has a valid DMOST order and/or verbalizes that they are a DNAR/No CPR then a purple wristband/bracelet will be placed on the patient's wrist. (**This identification method will be discussed with patient during Goals of Care discussion.)
- The physician ordering the chemotherapy/biotherapy infusion will review treatment limitations and/or any existing DNAR/No CPR order with the patient and/or legal representative prior to each infusion.
- The physician will document the discussion and communicate to the nursing staff any changes that are applicable.

In the event of DOWNTIME, communication regarding Treatment Limitations will be documented on Form No. 10162 Physician Orders.

C. TCC Office Visits:

During each office visit, there will be a question in the questionnaire that is reviewed with the patient that asks if the patient has a DMOST. If the patient has a DMOST that orders that the patient does not want to be resuscitated (DNAR/No CPR), then an Icon in the EMR (purple bow) will be added to show that the patient is not to be resuscitated.

Specific to the Adult Activity Center/The Gull House:

a. If a client arrives to the Gull House with a DMOST, it will be reviewed and orders will be placed and followed accordingly.
b. If the instructions on the DMOST are for DNAR/No CPR, then the following occurs:
    i. Copy of DMOST (not original) placed in pink envelope (acquired from State of Delaware) and place as page 1 in chart
    ii. Outside of chart has a large pink square secured to chart's spine
    iii. Client ID tag secured with pink yarn and visible on client

WITHDRAWING OF LIFE-SUSTAINING PROCEDURES OR CARE:

A. Discussion of withdrawing life-sustaining procedures:

For the purpose of limiting or withdrawing life-sustaining procedures, an Advance Directive, and/

or use of a legal representative BECOMES EFFECTIVE ONLY when:

- the patient lacks decision-making capacity AND
- the patient has been certified to be in a Qualifying Condition in writing by two physicians (and when the condition in question is "permanently unconscious" the 2nd physician shall be a board-certified neurologist and/or neurosurgeon)

1. The physician will have a full and sufficient discussion with the patient and/or legal representative concerning the nature of the illness, the prognosis, and the options for treatment including palliative/supportive care and recommendations regarding treatment limitations.

2. The physician is responsible for documenting any and all conversations with patient/family and their understanding in the patient's medical record.

3. Patients with decision-making capacity have the right to make treatment decisions for themselves, including refusal of life-sustaining treatment and withdrawal of life-sustaining care or procedures.

4. When patients no longer have decision-making capacity and have left no Individual Instruction (in writing or verbally) in regard to limiting or withdrawing treatment the patient's Guardian, Agent or Surrogate (in that order) will act on the patient's behalf in consultation with the responsible physician when the patient has been certified to be in a Qualifying Condition

   For information on who can act as the patient's legal representative when the patient no longer has capacity, see policy, "Surrogates, Agents, and Guardians in Health care Decisions" in the Patient Care Manual

SPECIFIC TO PREGNANT PATIENTS: – orders to withhold or withdraw life-sustaining treatment cannot be written for pregnant patients as long as it is probable that the fetus has the potential to be viable outside of the uterus.

B. Ordering withdrawal of life-sustaining procedure:

There must be a physician order/order in the Electronic Medical Record. The order must include, but not limited to, withdrawal of life-sustaining procedures and comfort measures.

RESOLUTION OF CONFLICTS OR WHEN AGREEMENT CANNOT BE REACHED:

1. The first step in conflict resolution should be open communication among all parties. Representatives of Beebe's Patient Experience Department, to include the Patient Advocate, are available to facilitate the process. Other resources that may be used to facilitate effective communication and foster understanding may include:
    - Other physician consultants
    - Chaplain
    - Palliative Care Team

2. Consultation with the Bioethics Committee or with individuals designated by the Bioethics Committee Policy may also be used to facilitate conflict resolution.

3. If conflict remains unsolved, patient or their legal representative has the right to request another physician and/or transfer to another facility.

4. If physicians and/or nurses/other clinical staff are in conflict with the patient's requests and/or physician orders regarding life-sustaining or withdrawing procedure, they have the right to have their professional and ethical integrity respected by transferring the patient care responsibilities to another physician or nurse.

REFERENCES

1. Delaware Code, Title 16, Chapter 25, Health Care Decisions (2019)

2. Morrison L J, Kierzek G, Kiekema DS, et al. Part 3: Ethics: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular care. Circulation. 2010 Nov 2; 122(18 Suppl 3): S665-S675

3. American Heart Association, ACLS: Principles and Practice. Dallas: 2003. p. 1. ISBN 978-0-87493-341-3.