Children's Code Status Communication Process

Introduction

The Children's Code Status Communication Process aligns with the state of Minnesota's **P**rovider **O**rders for **L**ife **S**ustaining Treatment (**POLST**).

This design allows the clinical team to update and easily view the wishes of the patient/family regarding their code status. The Code Status PowerForm includes the following tabs:

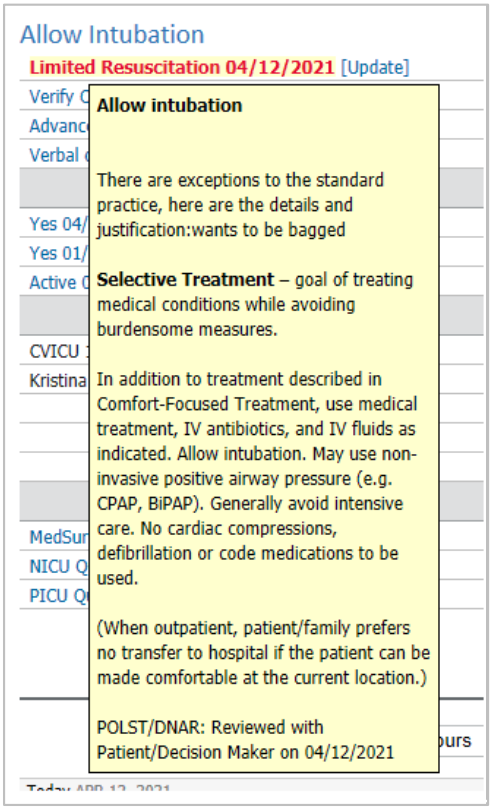
- **Code Status/DNR**: Information pertinent to the use of resuscitation in the event of an emergency in ED, ICU, or other inpatient unit. It is also used to modify code status in specific circumstances, e.g., anesthesia providers can change **Limited Code Status** to **Full Code for Procedure** in this tab.
- **Verify-Outpatient POLST**: Information applicable to outpatient resuscitation preferences
- **Edit-Advanced Care Planning**: Information about advanced care planning preferences in key conversations over time

A series of alerts are also available to guide the necessary steps with each patient status change.

Key Information

- There are three code statuses:
  - Full Code
  - Full Code for Procedure
  - Limited Resuscitation
    - Selective Treatment
    - Comfort Care
- Verifying one tab does not imply that information in all three tabs has been discussed. **Do not click** on a tab that you do not plan to edit.
- An attending doctor, nurse practioner, advanced practice RN, fellow, and physician assistant can complete the Code Status PowerForm/POLST.
- **Family does NOT need to sign** documentation to change code status.
- Code Status is **not an order.**
- Only one powerform is needed, the **Code Status PowerForm.**
- **Do NOT modify a powerform** from a previous code status. A new powerform can be opened via Clinical Highlights or alert action.
- Code Status **does not expire**. It requires verification by the attending service at admission, discharge and if level of care changes. Anesthesia is responsible for verification on day of procedure.
- Staff who respond to codes or provide end-of-life care must know where to view code status in the banner bar and the detailed information in the Clinical Highlights component.
- Providers can document code status preferences; all other clinical team members can view only.

- Outpatient Code status prints on the **POLST** in the format most familiar to Emergency Medical Services in our communities.
- The POLST will automatically print to the unit default printer when the Patient Discharge order is entered.
- This model allows care providers to quickly view information pertinent to the patient/family's resuscitation preferences in the event of the patient's declining health.
- New functionality is available in Clinical Highlights:
    - Hover on Code Status, POLST Status, or Advanced Care Planning to view documented information in a yellow box
    - Selecting the status allows you to see the full read only document
    - Click the **Update** hyperlink to open the powerform and update details



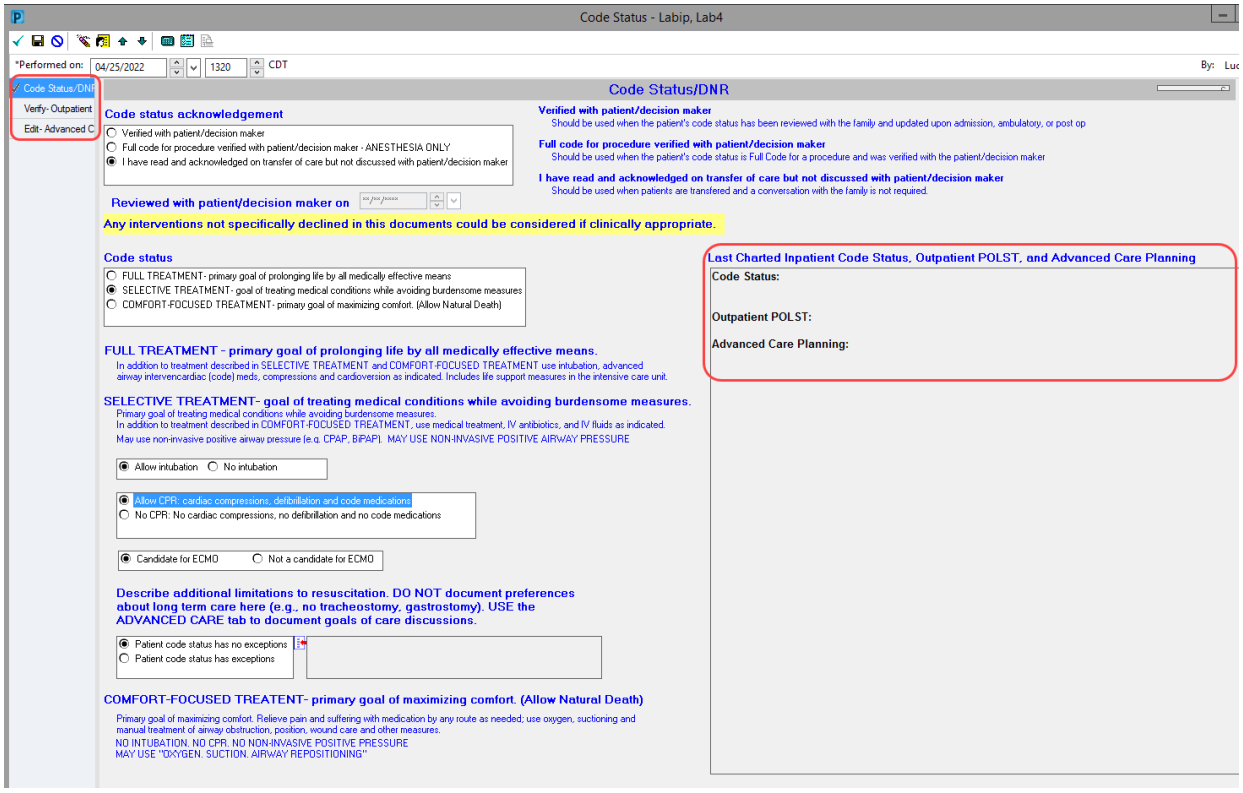
Code Status PowerForm

Verifying one tab does not imply that information in all three tabs has been discussed. **Do not click** on a tab that you do not plan to edit.

Code Status/DNR tab

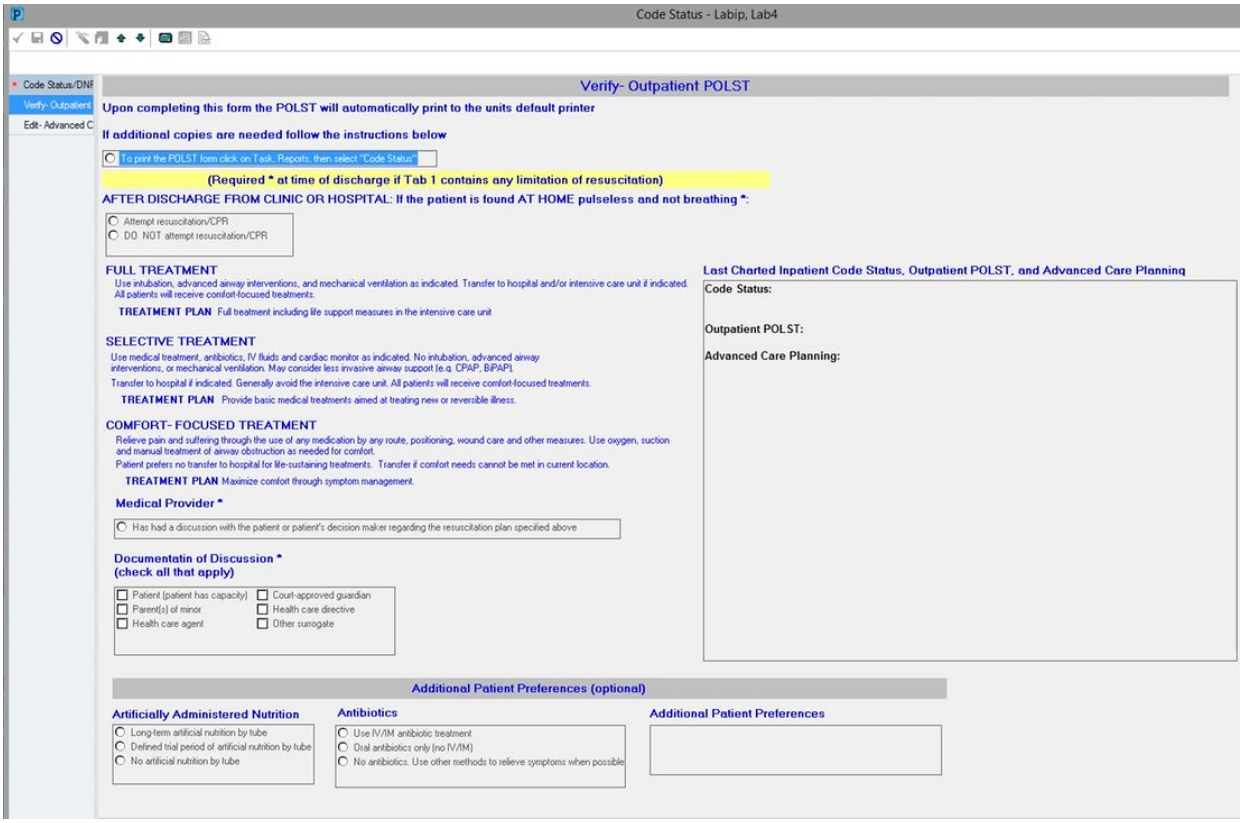
- Used to communicate code status information in the event of an emergency at the point of care in ED or ICU. Verification needed by the attending team at the time of admission and transfer to ensure that the responsible team has correct information.
- The **Code status acknowledgement** field is a required field. If documenting in another tab, this field must be addressed.
- To document in the **Code Status** field, you must first select an option from the **Code status acknowledgement** field.

- Resuscitation preferences are grouped into three levels of intervention that medical providers can recommend based upon the patient and family's goals of care:
    a. **Full resuscitation** specifies that all medically available options are to be used to extend life.
    b. **Selective treatment** specifies that the patient should be treated in the hospital for potentially reversible causes, with ICU care and non-invasive positive pressure respiratory support if needed. You must choose:
        - **Allow intubation** or **No intubation**
        - **Allow CPR** or **No CPR** (compressions, defibrillation & code meds)
        - **Candidate for ECMO** or **Not a Candidate for ECMO**
    c. **Comfort care** specifies that all comfort measures will be offered including suction, oxygen, medications but increased respiratory support, intubation, cardiac resuscitation, and ECMO will not be attempted.
- These levels are the standard of care, however in specific circumstances alterations need to made about the use of specific interventions and this information can be added in the free text section.
- The information in the Last Charted Inpatient Code Status, Outpatient POLST, and Advanced Care Planning section in the lower right on the Code Status/DNR tab presents a view of prior documentation from the Code Status/DNR, Verify-Outpatient POLST, and Edit-Advanced Care Planning tabs.



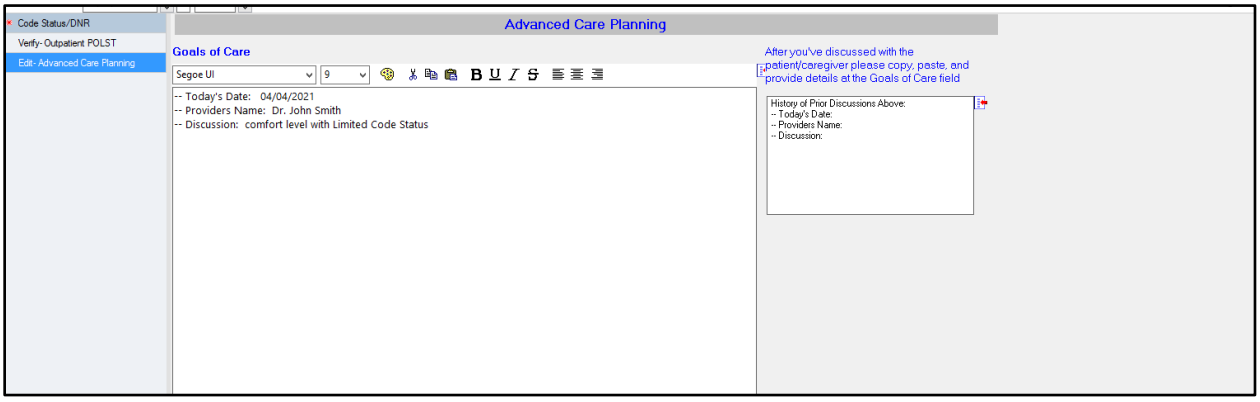
Verify-Outpatient POLST tab

- Adds information for EMS/pre-hospital responders on how they should intervene when the child is at home
- Requires verification before discharge from the hospital
- Information from **Code Status/DNR** and **Verify-Outpatient POLST** tabs populate a printed copy of the POLST for families to use when communicating their resuscitation preferences when outside of the hospital



Edit-Advanced Care Planning tab

- Provides a historical view of key conversations that may be relevant to changes in the patient's condition



Alerts

Each alert provides clear instructions on how to address code status.

Admit

Patient has a prior **Limited Code Status**. An *Admit to Inpatient* or *Place in Observation* order has been entered.

Action:

- Accepting medical team must **verify** code status within 24 hours. The attending team must ask the parent/guardian whether the code status information listed in Cerner is correct and either sign the current code status or make appropriate adjustments to accommodate family's preferences.

Transfer

Patient has a **Limited Code Status**. A *Change Level of Care* or *Change Attending and Level of Care* order has been entered.

Action

- Accepting medical team must **acknowledge** code status. The new attending team must familiarize themselves with the patient's limited code status and check the box to indicate they are aware. This does not require a specific conversation with the family unless their wishes have changed.

Surgery/PreOp

Patient has a **Limited Code Status** and is scheduled for a surgical procedure today.

Action

- Anesthesia must discuss Code Status during the procedure with patient's parent/caregiver beforehand. Just prior to the procedure the code status can be changed to *full code for procedure* if appropriate and returned to *limited resuscitation* afterwards.

Surgery/PostOp Inpt

Patient has a **Full Code for Procedure** charted more than 8 hours ago.

Action

- Attending medical service must address the Code Status and return to *limited resuscitation* if appropriate

Discharge

Discharge Patient order signed with **Limited Code Status**. **No Outpatient POLST** has been documented.

Action

- Patient needs to be returned to appropriate code status consistent with their plan of care.
- POLST needs to be documented.

Discharge

Discharge Patient order signed with **Full Code for Procedure**. **No Outpatient POLST** has been documented.

Action

- Patient cannot be discharged with **Full Code for Procedure**
- Patient needs to be returned to appropriate code status consistent with their plan of care

Discharge

Discharge Patient order signed with **Limited Code Status**. An **Outpatient POLST** has been documented.

Action

- POLST needs to be printed

Discharge

Patient has a **Full Code for Procedure** documented which must be updated prior to discharge.

Action

- Patient cannot be discharged with **Full Code for Procedure**
- POLST needs to be documented and printed. Patient needs to be returned to appropriate code status consistent with their plan of care.

Outpatient

In an outpatient setting, there are no alerts. When patient presents for the clinic appointment with **Limited Code Status** or **Full Code,** the following actions may apply.

Action

- Clinician must document any changes to the code status
- Print copy of POLST form if changes were made