Beth Israel Lahey Health

COVID-19 Code Status/Attempted Resuscitation Policy
Issued 4/6/20

Our duty to treat patients with respect and dignity is always at the forefront of the care we provide. Accordingly, we should understand patients' goals of care and offer only those interventions that are consistent with such goals. This is particularly important during this public health crisis, regardless of whether the patient is COVID-19 Positive or is presenting with other serious illness. Time permitting, all care teams should discuss patient goals and wishes as soon as possible in the course of any illness *and* with a change in the patient's clinical status.

Because COVID-19 is new to clinicians and patients, it is imperative that clinicians have a frank conversation with COVID-19 Positive patients and their families about what presence of the disease means for chances of survival, in particular the likelihood of success of cardiopulmonary resuscitation (CPR). While our understanding of outcomes in patients with COVID-19 is evolving, at present it is felt that mortality is highest in elderly patients and those with underlying medical co-morbid conditions. Further, for critically ill patients, COVID-19 may indicate a prognosis worse than the already poor (< 15%) estimated survival of CPR in critically ill patients overall. It is essential that providers share with patients and families as accurate a prognosis as possible.

If the clinical assessment is that attempts at resuscitation are expected to be harmful, ineffective or of no medical benefit (e.g., unlikely to lead to patient's survival to hospital discharge), this should be compassionately conveyed to patients and families. Only with this information will they be able to decide if an attempt at resuscitation would still reflect their goals and wishes in the setting of a poor prognosis. Clinicians also must make clear, however, that a patient's decision to forego resuscitative efforts (Do Not Attempt Resuscitation (DNAR)) will not impact other aspects of the patient's care, including their eligibility for a ventilator if one becomes necessary.

Along these lines, decisions for an individual's treatment options are specific to that patient. Attempting resuscitation on a patient with COVID-19, assuming such is consistent with their goals, may be appropriate and possible to perform safely. Personal protective equipment (PPE) must be in use by all members of the healthcare team before assisting a patient. Medical personnel should not perform CPR without adequate PPE. If PPE is not immediately available, it should be obtained prior to assisting. Additionally, clinical teams should limit the number of clinicians in the room while attempting resuscitation to further minimize the risk of transmission. If resuscitative efforts have a reasonable chance of success in such a scenario, then such efforts should be made. Conversely, if the clinical team determines that resuscitative efforts do not have a reasonable chance of success in in light of the need for PPE and the patient's clinical situation, then CPR should be considered "ineffective" and the institution's policy on ineffective treatments should be followed.

Each institution within Beth Israel Lahey Health (BILH) has its own policies regarding attempting resuscitation/patient code status and providing interventions that are clinically determined to be harmful, ineffective or of no medical benefit. Those policies remain in effect, unless otherwise modified at the institutional level, other than as described below for a subset of COVID-19 patients during a time of ventilator scarcity.

Crisis Standards of Care

If Beth Israel Lahey Health (BILH) activates Crisis Standards of Care during the COVID-19 pandemic because of a shortage of critical care resources, such as ventilators, the system will transition from care focused on maximizing individual patient benefit to that of maximizing the public good by saving the most lives and life-years. Allocation criteria ensure that the scarce resources are provided first to those who are most likely to benefit from such resources, and that the process of allocation is fair. When the BILH policy regarding allocation of scarce resources is activated, the following will be applicable for all patients in BILH:

1. Patients who presently need but are not allocated a ventilator pursuant to the allocation policy will be considered DNAR. It is not supportable to start CPR on a patient with an inability to escalate or intubate.
2. All patients, with or without COVID-19, who may reasonably be anticipated to need resuscitative efforts should be assessed for priority of receiving ventilatory support, should it become necessary. If the patient would not receive a high enough priority for the subsequent critical care required for continued survival (assuming they survived resuscitative efforts), then the patient should be considered DNAR.
3. If upon reassessment of the patient and the system resources, a patient's priority scoring changes such that they are allocated a ventilator or would be if it became necessary, their code status should be reassessed and determined according to the institution's then-current relevant policies (i.e., re: code status and ineffective interventions).