Yale New Haven Health
Resuscitation Protocol for the COVID-19 Pandemic

UPDATED – December 10, 2020

Background and Purpose

On March 13, 2020, President Donald J. Trump declared a national emergency in response to the global pandemic resulting from the rapid spread of Coronavirus Disease 2019 (COVID-19). This federal declaration followed various state declarations of public health emergencies and civil preparedness emergencies, including an order issued by Governor Ned Lamont in the State of Connecticut on March 10, 2020, as well as orders issued by Governor Andrew M. Cuomo in the State of New York on March 7, 2020 and an order issued by Governor Gina M. Raimondo in the State of Rhode Island on March 9, 2020. This "state of emergency" will remain in effect until further action is taken by these elected officials. During this time, federal and state agencies are authorized to take various extraordinary actions to limit the spread of COVID-19 and protect public safety.

In response to this unprecedented global public health emergency, Yale New Haven Health System (YNHHS) is implementing this Protocol to ensure that the highest quality care is provided to the most patients under the circumstances, which includes ensuring the safety of health care workers and their continued availability to care for patients.[1] The purpose of this Protocol is to appropriately balance the primary objective of maximizing lives saved with the need to provide protection and clarity for treating providers on the front lines of patient care in furtherance of the primary goal.

Guiding Principles and Goal

YNHHS is guided in all things by its mission, vision and values, including its overarching commitment to excellence in patient care that values all people with compassion and empathy. At the same time, the safety of YNHHS' clinical staff is of critical importance in sustaining a functioning healthcare system and limited resources must be allocated to maximize lives saved during the public health emergency. Accordingly, the primary goal of this Protocol is to maximize care for patients consistent with clinical goals while ensuring that appropriate personnel remain available to provide care. These principles will underpin all decisions and actions taken in furtherance of the Protocol.

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[1] This Protocol was specifically developed in response to COVID-19. Future epidemics may vary in ways that would change the optimal terms of care described herein. This Protocol will, therefore, be effective only as described under "Effective Time".

The Protocol was prepared in reference to the "Standards of Care: Providing Health Care During A Prolonged Public Health Emergency" prepared by the Standards of Care Work Group of the Connecticut Department of Public Health (October 2010) (https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/legal/StandardsofCarefinalpdf.pdf?la=en).

Effective Time

This Protocol shall be effective immediately and will remain in effect until expressly terminated by the YNHHS Chief Clinical Officer or his designee or the state of emergency has been declared to have ended in the applicable jurisdiction.

Notification of Effective Time

A System-wide notice of this Protocol shall be issued to all staff. In addition, the YNHHS Chief Clinical Officer, in collaboration with the YNHHS Chief Executive Officer and YNHHS Senior Vice President and General Counsel, or their designees, shall determine an appropriate manner of notifying the public, patients and other stakeholders.

Applicability of Protocol

This Protocol will apply to all adult and pediatric (including neonatal) patients at all YNHHS hospitals based on the below protocol.

Protocol re Code Status and CPR

YNHHS respects, protects and supports each patient's rights, including the right to take part in decisions about care and treatment.[2] Accordingly, clinical teams will make every effort to discuss matters of code status with patients and/or surrogates as early as possible upon admission or presentation to the emergency department. In some circumstances, aggressive resuscitation efforts are unlikely to benefit the patient and may be traumatic and painful without a likelihood of changing chances of survival. In cases where aggressive resuscitation efforts are not recommended by the clinical team, clear information will be provided to patients and/or surrogates and attempts made to obtain assent to assignment of a code status of "Do Not Resuscitate" (DNR)[3] when clinically appropriate.

Providers must be careful not to coerce patients or their families to make particular advanced care planning decisions for the good of the facility or due to perceptions of quality of life or relative worth. Providers may not impose blanket DNR policies for reasons of resource constraint. Providers may not require patients to consent to a particular advanced care planning decision in order to continue to receive services from a facility.

There may be circumstances where the assent of the patient/and or surrogate is not or cannot be obtained but in the opinion of the two physicians changing the code status is appropriate because, in light of the patient's medical status, in the event the

[2] Patient Rights and Responsibilities for YNHHS hospitals are available online at ynhh.org.

[3] Patients assigned DNR code status will not receive cardiopulmonary resuscitation (CPR) or other advanced cardiac life support in the event of a cardiopulmonary arrest.

patient degrades to the point where aggressive resuscitation efforts would be needed, such patient would at that time be in a terminal condition as disease progression at that point would be irreversible and reasonably likely to lead to death. In such circumstances, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status and documentation of such efforts must be included in the medical record. If assent cannot be obtained and transfer is not available,[4] during the effective time of this Protocol, the following will apply:

1. **Critically Ill Patients with COVID-19.** The benefit of providing cardiopulmonary resuscitation (CPR) to critically ill patients with COVID-19 is likely to be low in most cases. CPR also exposes healthcare workers to high risk of infectious transmission. In addition, for certain of these patients, intubation may be dangerous or futile. For these reasons, attending physicians may, without the prior authority of the patient or surrogate, assign code status of DNR to critically ill COVID-19 positive patients where, in the good faith, best medical judgment of two attending physicians, it is determined to be clinically appropriate and that aggressive resuscitation is unlikely to benefit the patient because in the event such efforts were required, the patient would be in a terminal condition with an extremely low likelihood of survival to hospital discharge. Prior to changing the patient's code status, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status and documentation of such efforts must be included in the medical record.

2. **Critically Ill Patients with suspected or confirmed COVID-19 in the Emergency Department.** Attending physicians may, without the prior authority of the patient or surrogate, assign code status of DNR to patients in the emergency department who are suspected or confirmed to have COVID-19, where, in the good faith, best medical judgment of two attending physicians, it is deemed to be clinically appropriate and that aggressive resuscitation is unlikely to benefit the patient because in the event such efforts were required, the patient would be in a terminal condition with an extremely low likelihood of survival to hospital discharge. Prior to changing the patient's code status, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status and documentation of such efforts must be included in the medical record.

Treating physicians may reverse DNR code status that is assigned without patient or surrogate assent if a patient's condition has improved and the physician determines that the change in code is clinically appropriate. Treating physicians may also reverse DNR code status that is assigned without patient or surrogate assent if they believe

[4] During the public health emergency, it is acknowledged that transfer of patients to other facilities will likely not be possible for various reasons, including medical urgency, lack of availability, and increased risk of exposure to health care providers and others during transport.

cardiac arrest is due to a reversible cause that will not require prolonged cardiopulmonary resuscitation. Typical examples might include VT/VF arrest in the setting of electrolyte abnormalities or acute coronary syndrome.

DNR status maybe temporarily reversed during invasive procedures at the discretion of the operator.

Patients who choose not to receive critical care support will be assigned mandatory DNR status without exception.

Documentation of Change in Code Status

All changes to code status should be documented, including (i) the evaluation and agreement of a second attending physician that the patient is unlikely to benefit from CPR or intubation due to extremely low likelihood of survival to hospital discharge; and (ii) good faith efforts to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status.

Changes to the Protocol

This Protocol is subject to periodic reassessment and revision by the YNHHS Chief Clinical Officer in consultation with the YNHHS Chief Nursing Officer, YNHHS Senior Vice President and General Counsel, and YNHHS Medical Director of Medical Intensive Care.

Effect of Protocol on Other Policies

This Protocol, while in effect, supersedes the requirements set forth in the YNHHS Conscientious Practice Policy or any conflicting existing policy.

Initially adopted April 10, 2020, updated April 21, 2020, April 28, 2020, May 29, 2020, and November, 12, 2020.