



**Department of Medicine
Internal Medicine Residency Program**

RESUSCITATION TEAM RESPONSIBILITIES

1. Code pagers are furnished to all on-call Internal Medicine housestaff who are scheduled to carry the code pager. It is the responsibility of the post-call housestaff to hand off the code pager to the on-call resident. However, if the on-call resident will be out of the hospital for any reason (conference, clinic, etc.) it will be their responsibility to inform the post-call resident still in possession of the pager. This is to facilitate the post-call person being able to leave rather than waiting to pass off the code pager. All housestaff carrying code pagers are required to remain in-house.
2. A code leader (Medicine resident) is responsible for directing all other participants in the code. The leader shall designate duties and direct all interventions. Only personnel designated by the leader shall be involved in resuscitative efforts.
3. The physician leader of the code will be the resident on-call in the MICU. The team leader will be identified to the entire code team present.
4. The anesthesiologist will provide access to the airway and ventilation as assisted by the respiratory therapist. It is NOT the responsibility of the anesthesiologist to run the code.
5. The MICU resident will provide or assign personnel to perform chest compressions, ECG rhythm interpretation, drug recommendations, and observation of vital signs. The team leader will provide overall direction of the code, as per ACLS guidelines. The other Medicine resident should perform procedures, such as attaining central access, as deemed necessary by the code team.
6. The physician leader of the code, in cooperation with a physician representative of the patient's primary care team (when available), will determine the extent to which unsuccessful resuscitative efforts should be continued.
7. The resident representative of the service primarily responsible for the patient's care is responsible for notification of the patient's attending medical staff member (faculty person) and family. If no physician service representative is available, the code leader should assume this responsibility.
8. All medicine housestaff must be ACLS certified.
9. Patients who survive resuscitative efforts and require transfer to the ICU are the responsibility of the code team and/or primary care team until transfer to the ICU team.

All members of the code team are responsible for the physical transfer of the patient to the ICU. The physician code leader must write a detailed code note on all patients.

10. In the Ashley River Tower, the MSICU resident will be the code team leader.

Declaration of Death/Death Notes/Autopsies

At the conclusion of an unsuccessful code or in the event of the death of a patient who did not wish to be resuscitated, the primary team physician or the on-call physician will be required to pronounce the patient dead. The physician performing this service will have the following responsibilities:

- Examination of the patient and confirmation of death
- Complete death note on “discharge as deceased” tab in EPIC
- Informing the Charge Nurse of the death
- Notification of the patient’s family and the Attending Physician of the primary team

Example of a Death Note

“Called to see patient for lack of respiration and pulse. On examination, patient was found to have no spontaneous respiration. No pulse could be palpated or auscultated. Pupils were fixed mid-position without reaction to light. There was no response to deep pain stimuli. (If applicable) Patient had requested that no resuscitative efforts be undertaken given the terminal nature of his/her disease. We have complied with these wishes. Patient was pronounced dead at 2135 today, July 1, 2011. Patient’s family, Attending Physician and chaplain notified.”

The signature of the pronouncing physician must follow the death note and must be legible. The pager number should also be included with the signature. Notes following an unsuccessful code will document the performance of the code by ACLS protocol, outlining the medications and maneuvers utilized during the code. An autopsy on the deceased patient should be offered to family members. If applicable, organ donation should be discussed with the family. The chaplain assists the family with funeral arrangements.

Do Not Resuscitate/Withdrawal of Life Support

A competent patient may, at any time, verbally request or consent to an order for “Do Not Resuscitate” or “Withdrawal of Life Support.” IF the patient later becomes incapacitated, the previously expressed wishes will be upheld. Key points are listed below:

1. Used only for competent patients.
2. The Attending Physician must be contacted to take part in any decision-making after hours and during on-call time.
3. If the patient or family members do not feel comfortable with the decision, the Attending Physician must be contacted.
4. The Attending Physician must document within 24 hours in the medical record that the patient is terminally ill and that resuscitation would merely prolong dying.
5. Family may be consulted only with the patient’s permission and have no legal rights to intervene. With some exceptions, it is inappropriate for the cross-cover teams to discuss “Do Not Resuscitate” considerations other than when the family or patient specifically approaches the on-call team in that regard. If it is deemed necessary for the cross-cover team to address code status, the primary attending should be contacted first.

6. All reasonable efforts must be made to contact the next of kin for incompetent patients. If no disagreement exists between available family members, a decision may be made on that basis.
7. If no relatives exist for an incompetent patient or a family disagreement exists, a legal guardian should be sought. Ethics consults are available 24 hours/day and may be helpful in difficult situations.
8. Chart documentation should include notes by a faculty member and an order that resuscitative efforts not be used in the event of a cardiopulmonary arrest.
9. In the case of "Withdrawal of Life Support," a written statement in the medical record by the attending physician is required.
10. Re-document the code status upon transferring a patient from one service to the next.
11. It is appropriate for the primary team to discuss code status with patients when they first enter the hospital, especially in those cases when the prognosis is uncertain.
12. When documenting in the chart, "DNR" is not sufficient. The words "Do Not Resuscitate" must be written in full and be legible.

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