Source and Credits

- This presentation is based on the December 2019 AHRQ WebM&M Spotlight Case
  - See the full article at https://psnet.ahrq.gov/webmm
  - CME credit is available
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Objectives

At the conclusion of this educational activity, participants should be able to:

- Recognize the importance of a comprehensive, personalized discussion of code status with all hospitalized patients.

- Differentiate among terms associated with advance care planning and code status.

- Identify at least four tools available for clinicians and patients related to advance care planning and code status.

- Determine systems approaches that facilitate advance care planning between the healthcare team, patient, and family to include the designated surrogate.

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Case: "Do You Want Everything Done?"

A 63-yo woman with hx of liver transplantation 2° to hepatitis C, low back pain, and depression presented with hematemesis (vomiting blood). She was generally healthy, working, and engaged with family. A 2nd yr medical resident admitted her, ordered appropriate diagnostics & therapeutic interventions. The resident asked if the patient "would want everything done" if she were to get sicker. The patient replied, "You know, I don't think I'd want to be kept alive on machines, that's for sure." The resident interpreted this to mean the patient would not want resuscitation under any circumstances and decided the code status should be do not resuscitate and do not intubate (DNR/DNI). Unfortunately, the resident forgot to enter this update into the EHR so the patient remained a "full code."

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Case: "Do You Want Everything Done?" (2)

In the morning, the admitting resident presented the case to the daytime medical team, including the DNR/DNI code status. The team was somewhat surprised by the code status given the patient's general good health. That afternoon, the attending physician and intern met with the patient to discuss her wishes. In a longer conversation, the patient clarified that she would not want chest compressions (as she had seen her husband receive these in the past when he died) but would accept short-term mechanical ventilation for reversible causes. She repeated that she would not want prolonged mechanical ventilation. Based on this, they deemed her code status to be "partial code."

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Case: "Do You Want Everything Done?"(3)

The patient was taken for an endoscopy and was intubated for the procedure. In parallel, the intern placed the order to change the patient's code status from "full" to "partial" code. Right after intubation, the anesthesiologist and gastroenterologist noticed the change in code status. They were no longer comfortable proceeding, because they lacked the ability to respond fully with resuscitation if something were to go wrong during the procedure. Yet, the patient was already intubated and sedated. They urgently contacted the daytime medical team, and the teams met briefly.

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Case: "Do You Want Everything Done?"(4)

Under the circumstances, they realized they had three options: (a) proceed with the procedure without changing the code status and assume the risk that, if something went wrong with the procedure, the patient could not receive chest compressions and may die; (b) extubate without performing the procedure, discuss the decision with the patient, and potentially reintubate if that was consistent with her wishes; or (c) change the code status without the patient's explicit consent and proceed with the procedure. In the end, they believed the third option best respected her wishes and minimized harm, so her code status was change to "full code." They completed the procedure and then discuss with the patient afterward. The endoscopy was performed without any complications and the patient was extubated.

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General Response to the Case

- Significant errors were noted in this scenario revealing multiple opportunities for improvement

  - Advance care planning (ACP) and determination of specific treatment wishes must be prioritized

    - Healthcare team must provide appropriate discussion of risks, benefits and alternatives so that the patient (or surrogate) can make informed decisions

  - There should be a named surrogate who can make decisions if the patient is unable

  - Care preferences must be entered into the EHR so everybody on the team is aware of them in the event the patient's condition deteriorates

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Significant Error 1: Opportunities for Improvement

- Admitting resident's "discussion" was inadequate and lacked in depth discussion of patient preferences
  - Medical professional should NOT use, "Do everything" or "Do nothing" when discussing treatment preferences
  - Simplistic language in the interest of expediency fails to afford patients/families an opportunity to explore what "do everything" means
- Resident did not explore what "I don't want to be kept alive on tubes and machines" meant and instead considered patient "DNR/DNI"
- Clear and concise communication about the meaning of each decision and ensuring the patient understands what they have decided is critical

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Significant Error 2: Opportunities for Improvement

- Failure to obtain patient surrogate to make treatment decisions if she became incapacitated
  - Most important feature of advance care planning
  - Vital information for the resident to obtain and document on the initial encounter
- Named agent with contact information would have allowed the procedural team to call the agent for guidance instead of relying on medical team to make a proxy decision

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Significant Error 2: Opportunities for Improvement (2)

- Not wanting to be kept alive on machines does not necessarily denote lack of desire for short-term aggressive life support, particularly if there is good prognosis for recovery

- Best practice is to explore individual patient preferences, providing all options based on their condition

- DNR language is evolving in many places
  - Do Not Attempt Resuscitation [DNAR]
  - Allow Natural Death [AND]

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POLST Paradigm (polst.org)

- POLST*=Physician Orders for Life-Sustaining Treatment (https://polst.org/about-the-national-polst-paradigm/what-is-polst/)

  – POLST is intended for a limited set of patients

  – Patients appropriate for POLST conversation are those most likely to have a medical crisis but may not want everything possible done to save their life

- Advance Care Planning (ACP) is appropriate for most patients for end of life care planning
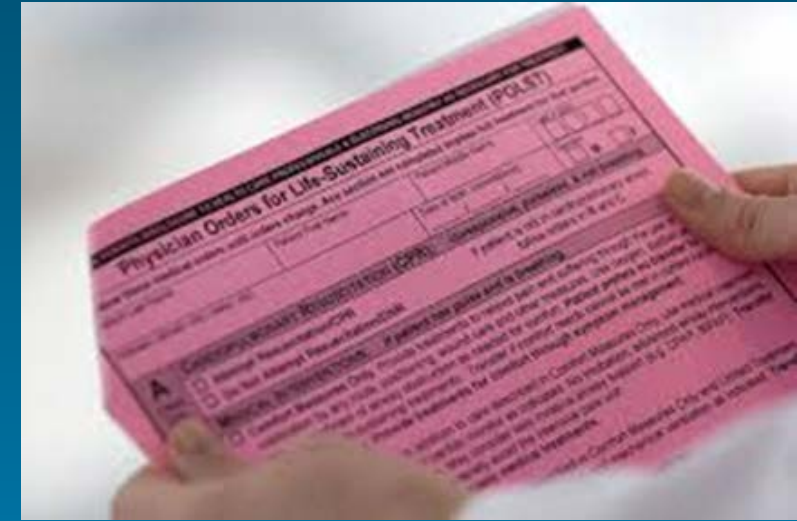
*Name varies by state such as MOLST= Medical Orders for Life-Sustaining Treatment

Do Not Attempt Resuscitation – DN(A)R

- DN(A)R only applies to situations of full cardiac and respiratory arrest
  - Patient can still wish other interventions (e.g., intubation)
- Healthcare providers sometimes misinterpret DN(A)R status to mean patient wants no efforts to prolong life
- Patients (and surrogates) may reject DN(A)R status because of misconceptions
  - Fear that care teams will not address acute changes in condition
  - Overestimation of CPR success rates
    - Hospital CPR survival from cardiac arrest to hospital discharge among **all** age groups and health status < 20% (2004-2014)
    - <5% in seriously ill or frail

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Significant Error 3: Opportunities for Improvement

- Failure to enter the code status order into the EHR could result in unfortunate consequences including preventable death

- Default code status in the absence of specific orders to the contrary is always to provide the most aggressive care, including CPR, defibrillation, intubation and ICU transfer

- If patients do **not** want aggressive or invasive interventions, failure to enter a DN(A)R order could resulted extreme and unfortunate consequences including:
  - CPR-related fractures, anoxic brain injury, prolonged disability
  - Failure to abide by a patient's known wishes could increase liability exposure

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Changing Code Status w/o Patient Knowledge

- Changing patient's code status without their or surrogate's knowledge is problematic
  - Ethically fraught area
  - Potential to harm a patient if an unexpected complication occurs
- In this case, there was no harm, but patient preferences were altered without her approval
- Additionally, some patients may not want CPR under any circumstances
- Bioethics and/or palliative medicine consultation may be appropriate to attempt to reach consensus in cases where there is dissention

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Health Profession Reluctance

- Tracking of mortality quality measures can have a chilling effect on a surgeon's willingness to perform procedures
  - An example is Orthopedists' reluctance to perform surgery on unstable hip fractures in seriously ill patients
  - Surgeons could convince family the patient is "not a surgical candidate" even in cases where the risk of death would be a preferable patient-centered outcome
    - Ex. Not performing surgery would leave patient in significant pain; death might be the patient's preference
- Clinicians should not allow concerns about metrics to color clinical decisions (e.g. keeping a patient alive to improve transplant survival statistics)

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Systems Approach to Improving Safety

- Appropriate training and supervision around ACP or goals-of-care conversations in medical school and postgraduate training

- Review of required residency hours to prevent fatigue and oversight of residency performance

- Systems-level interventions to "close the loop" so clinicians are knowledgeable and adept at having these conversations

- Ability to bill for these conversations reinforces their importance and should provide incentive for clinicians to discuss code status and ACP

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Helpful Tools

- VITALTalk and Ariadne Labs' Serious Illness Program provide tools for clinicians including:
  - Videos
  - Quick guides
- ACP Decisions and Coalition for Compassionate Care of California provide decision guides for patients
  - Videos
  - Short informational brochures with low-health-literacy descriptions of benefits versus burdens of CPR, tube feeding, artificial hydration, intubation/mechanical ventilation, etc.

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Advance Care Planning

- Discussions should include the patient and interested family members including
  - Designated health care agent (sometimes also called surrogate, representative, decision-maker, or proxy)
  - These agents are often erroneously referred to as "POA" or power of attorney, which is a document and not a person
- Ideally, this would include representatives from each health care team involved in the case

https://www.ncbi.nlm.nih.gov/books/NBK236845/

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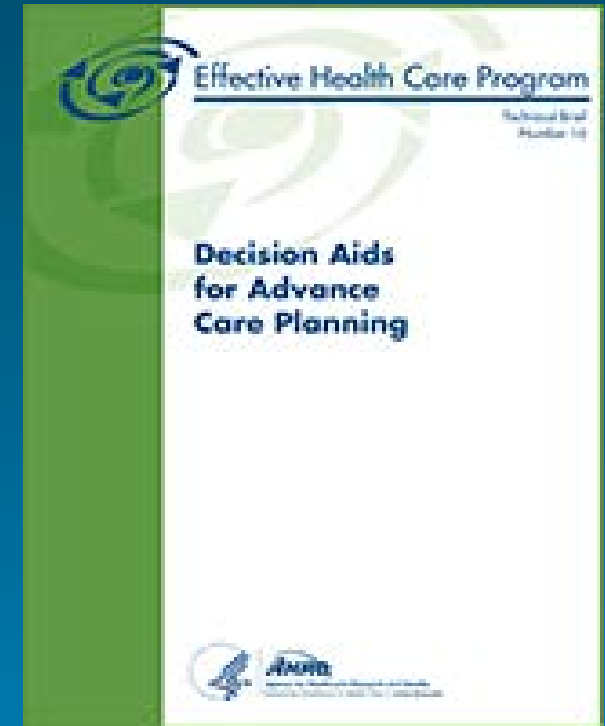
Timely Entry of Code Status in EHR

- Individual clinicians to place and modify code status orders promptly, given their extreme significance

- Unclear how the new code status order was not entered in time leaving the endoscopy team to be caught unaware

- When procedures are imminent, a direct phone call to the team to alert them to the new code status could prevent an adverse event

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Take-Home Points

- Code status discussions, "goals-of-care" and specific treatment preference conversations, and advance care planning in general, are critically important features of the care we provide.

- It is essential for healthcare providers to obtain a code status for patients that includes their individual preferences, surrogates, and goals for care. In the absence of a discussion, the default is to the most aggressive, invasive, potentially life-prolonging treatment.

- Patients must be provided all information necessary about risks, benefits and alternatives of treatments being considered for them to make informed decisions related to their preferences for potentially life-sustaining care.

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Take-Home Points (2)

- Patient-specific preferences should be entered into the medical record as soon as possible.

- Healthcare professionals need to understand the differences in the evolving terminology of advance care planning, i.e., No CPR, DN(A)R, AND, POLST and other terms.

- Communication among clinical specialties, nursing, and the entire interprofessional team is critical.

- Policies should be put in place to ensure there are resources such as Bioethics Committees in cases where consensus is not reached.

- Statistics and metrics should not create inappropriate treatment decisions that go against a patient's reasonable values and preferences.

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