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Code Status Discussions

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Code Status Discussions

Kelly Rabah, MSW, LISW-S, CPHQ

The 2 most Important Take-aways:

- Have the conversation early
- Fully disclose risks, benefits and alternatives

National Statistics about Full Code Effectiveness:

… "Many clinical reports have demonstrated that most physicians are not only inadequate in discussing code status with their patients but also have a tendency to avoid these discussions due to time constraints and fear of patient dissatisfaction. This lack of effective communication can result in medical mismanagement, unnecessary grief, and avoidable legal consequences."

Medpage Today- Brian J. Secemsky . April 3, 2013.

Un-extraordinary measures: Stats show CPR often falls flat

- Exact survival rates are difficult to come by, as studies generally look at specific populations.
- A 2012 study showed that only about 2% of adults who collapse on the street and receive CPR recover fully.
- Another from 2009 showed that anywhere from 4% to 16% of patients who received bystander CPR were eventually discharged from the hospital.
- About 18% of seniors who receive CPR at the hospital survive to be discharged, http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/CURRICULUM/Documents/Ehlenbach%20WJ--In-hosp%20CPR%20epidemiology%202009.pdf

By Madeleine Stix, CNN
Updated 7:18 AM ET, Wed July 10, 2013

Other Studies Show…

- Looking at 2,600 hospital cardiac arrests over four and a half years in Oakland County, Mich.,(2013), found that patients in their 40s and 50s had the highest rate of successful resuscitation: 10 percent. The statistics got only slightly worse with each decade:

- 8.1 percent successful resuscitation for patients in their 60s

- 7.1 percent in their 70s.

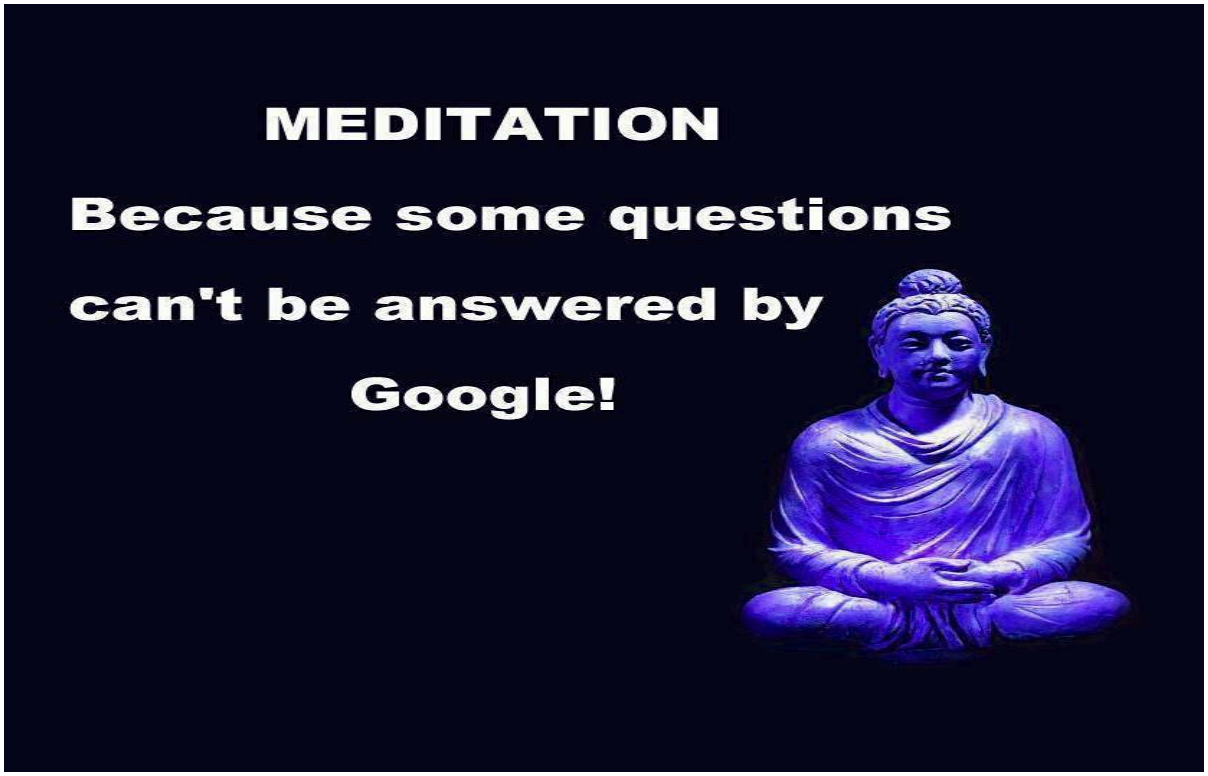
- Once a patient hits 80,only 3.3 percent survived to hospital discharge.

How Successful Is CPR in Older Patients?
By Paula Span August 9, 2012 1:12 pm
New York Times

“what would you want done if your heat stops beating?”

“ I want everything done.”

Have we explained what that really Means???



Yet and still, we pursue ever onward…

- https://www.youtube.com/watch?v=L1bbN08o6Y4

When do I Begin the conversation and how?

- **When?**
  - For older or chronically / terminally ill- upon admission- ONGOING.
  - For an acute injury / illness- as soon as you suspect the care episode may not end as expected

HOW?

- **What does the patient and family understand?**
- **Clarify the situation as needed and be direct**
- **Have they had conversations about wishes / advanced care planning?**
- **If not, what would or does the patient want in general terms…**

The "How" part 2:

- Pharaphrase what you believe you have heard
- Honor and acknowledge feelings
- Educate about options and validate "HOPE"
- Offer hospice and / or Explain DNR and DNRCC in simple terms & Execute

Reassure we don't stop caring- we ***change the focus of care***

Code Status should be a part of hospice discussions

- This may be the appropriate place to offer hospice as an option

Sometimes code status conversations can be delayed until hospice admit

- Hospice ***may not be*** an option if you expect the patient to code imminently **OR** if you are supporting the patient in order to maintain organ donation as an option

Ohio Revised Code- 3701-62

- Became effective in 1999
- **Two options within the DNR Comfort Care Protocol:**

  DNR Comfort Care (DNRCC) Order

  DNR Comfort Care-Arrest (DNRCC-Arrest) Order.

- **DNRCC Order:** a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life

  Appropriate for terminally ill
- **DNRCC-Arrest Order**, a person receives standard medical care until the time he or she experiences a cardiac or respiratory arrest. *More aggressive*

DNR PATIENT/DESIGNEE DECISION TREE

YES	NO	DECISION TO BE MADE	FULL CODE	DNRCC-Arrest	DNRCC
		Defibrillation	YES	NO	NO
		Chest compressions	YES	NO	NO
		Artificial ventilation (can be by bagging **or** ventilator)	YES	YES	NO
		Cardiac monitoring	YES	YES	NO
		ACLS drugs for resuscitation	YES	YES	NO
		Cardioversion	YES	YES	NO
		Resuscitative IV	YES	YES	NO

FULL CODE

- Everything will be done to prevent and/or reverse death

DNR Comfort Care-Arrest

- The following **may** be done to **prevent** cardiac or respiratory arrest
  - Artificial ventilation (including intubation)
  - Cardiac monitoring
  - ACLS drugs
  - Cardioversion
  - Resuscitative IV
- The following will **not** be done to **reverse** cardiac or respiratory arrest
  - Defibrillation
  - Chest compressions

In the event of cardiac or respiratory arrest, DNR Comfort Care guidelines will apply.

DNR Comfort Care

- **Only** the following will **not** be done; all other treatments not listed here can be done
  - Defibrillation
  - Chest compressions
  - Artificial ventilation (including intubation)
  - Cardiac monitoring
  - ACLS drugs for resuscitation
  - Cardioversion
  - Resuscitative IV

PHYSICIAN'S ORDERS

Drug Allergies

DNR Routine Orders

Date & Time _____

Doctor's Orders

1. ☐ DNRCC ☐ DNRCC-A (Includes intubation unless the answer to #2 is **No**)
2. If patient is a DNRCC-A, is patient to be intubated?
   ☐ Yes ☐ No
   - *If "No" to above, order is considered customized and does not allow for portability and immunity under Ohio Law*
   - *If "No" Place yellow "DO NOT INTUBATE" ID Band on patient*
   - *If customized, patient/designee are given an explanation from the physician that the order is not portable to the patient's home or nursing home setting.*
3. Place State of Ohio DNR ID form on chart for physician to sign
4. Give patient State of Ohio DNR ID form, wallet card, and bracelet after physician has signed the form
5. Place a "copy" of the State of Ohio DNR ID form on the patient's chart after the physician has signed it
6. Other

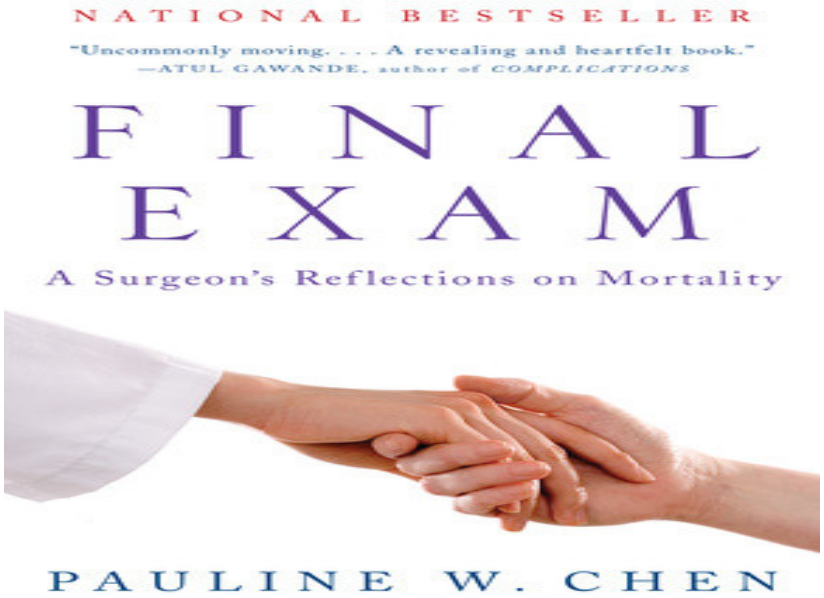
_____

_____

Done well- it makes every difference

- https://www.youtube.com/watch?v=-H6-yUpzdt4

FINAL EXAM- A Surgeons Reflections on Mortality



Paula Chen, MD:

- “Like many of my colleagues, I came into medicine ill-prepared to deal with death and dying…immobilized by my own fears and insecurities. At some point many years into my training, I realized that even greater than a cure I could provide, I could offer healing and provide comfort.. In doing so, I could open myself to some of life’s greatest lessons…”

Discussion

- What is the hardest part of this for you?
- What have you found particularly useful/ helpful?
- What have you found to be harmful to the process?