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Presumed vs confirmed full code

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A PATIENT’S STORY - DOES THIS SOUND FAMILIAR?

Mr. Adams is a 70 yo man admitted to the hospital for altered mental status at 2AM. He has never been a patient at this hospital, cannot provide his story, and there are no family members with him.

On the admission orders the patient is listed as FULL CODE. The patient is passed off to a daytime team.

Over the course of the next 3 days, the family arrives and is bedside, and work up and therapies continue with some improvement in his mental status.

On Day 3 the patient experiences a PEA arrest and the team begins resuscitation efforts.

The family intervenes and shows paperwork that has been present for the last day at bedside stating the patient is DNR. The code is halted after significant distress to family.

On review of the records, a code status note was not written and no information about code status was mentioned in the H&P.

The covering team and nurses on the floor state that they assumed that the patient was full code, and that a discussion took place, due to the order placed stating “FULL CODE”.

Conclusions

1. Hospital Medicine needs to take a more proactive role in ensuring that patients make informed decisions and receive all and only the care they desire.

2. We submit these standards we hope to be adopted by other institutions including:
   a. the use of ‘presumed’ and ‘confirmed’ code statuses
   b. the expectation to have code status discussions on all admissions
   c. identification of surrogate decision maker
   d. increased education to hospitalists on code status discussions

Background

Problems with Advance Directives (ADs)
1. ADs are rarely completed in outpatient and inpatient settings
2. Patients’ preferences regarding code status are often not elicited, or delayed to when a patient cannot participate or there is a crisis
3. Physicians do not provide adequate information to allow patients to make informed decisions about code status
4. Providers inappropriately extrapolate DNR orders to limit other treatments (such as artificial nutrition, ICU admission, etc.)

Most hospitals default to “Full Code” as the status for patients admitted, particularly in patients with whom a code status discussion cannot or has not taken place. In many cases, confirmation of “Full Code” does not occur later when these discussions become possible.

These problems can result in patients receiving care they would not wish or choose.

Purpose

At the University of New Mexico (UNM), an academic safety net hospital, a multidisciplinary Advance Directives Task Force formed to improve patient care at end of life. An initial survey found that <2% of inpatients had Advanced Directives (ADs). The goals of the task force were:

a. To improve access to and completion of ADs, and
b. Clarify patients’ wishes regarding CPR

Description

Actions undertaken by the Task Force over a 2 year period included the following quality improvement measures:

1. Revision of the hospital Code Status Policy:
   “All adult admissions will have a code status discussion, identification of a surrogate decision maker, and a code status note written. Code status orders are written for all adult inpatients and include the options of Presumed Full Code (for patients with whom a discussion cannot take place on admission), Confirmed Full Code (after discussion takes place with patient or surrogate), or DNR (eliminating “partial code” status orders).”

2. Process Improvements included:
   a. Modification of existing orders and order sets in EMR
   b. Development of standardized templates for code status discussion and surrogate decision maker identification notes (see below)
   c. Revision of patient handouts about Advance Directives in literacy appropriate language
   d. Education for physicians about “how to have a code status discussion”
   e. Hospital-wide education to all staff about these changes

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