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Code Status in the Inpatient Setting

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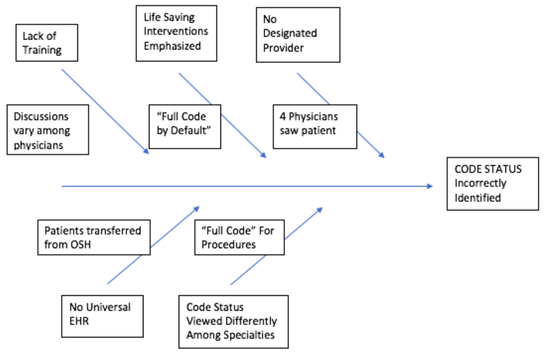
CLINICAL CASE

89M with PMH of chronic systolic HF, Atrial Fibrillation on chronic anticoagulation, Barrett's esophagus, and history of DNR on POLST forms in 2017 and 2022 presented from OSH with acute GI bleed. He had previously received pRBC and plasma and was documented as full code from OSH. At Sacred Heart, he was admitted with "full code by default." He was seen by admitting ICU resident in pre-GI scope area. Resident discussed code status with patient who reported DNR status. Patient subsequently taken to GI suite for EGD. Patient subsequently coded during GI procedure and underwent three cycles of CPR and epinephrine x2. Resident responded with CODE BLUD team and communicated DNR status. GI physician confirmed status in chart and with family in waiting area. CPR then aborted.

CASE HIGHLIGHTS

Critically ill elderly male patient with GI bleed mis-identified as FULL CODE during transfer from OSH and after being seen by four physicians



LACK OF TRAINING

Patient given CPR despite DNR status

-Delay in Code Status Conversation

--Code Status can be time consuming discussion

---Patient's lack understanding around Code Status

----Code Status discussions vary among physicians

Root: No universal training on code conversations

NO UNIVERSAL EHR

Patient given CPR despite DNR status

-Delay in Code Status Conversation

--Conflicting documentation about code status

---Patients can have outdated code status

----Medical records don't always update or transfer to receiving facility

Root: There is no universal EHR system and poor interaction between different ones

LIVE SAVING INTERVENTIONS EMPHASIZED

Patient given CPR despite DNR status

-Delay in Code Status Conversation

--Patient was "Full Code by Default"

---Patient required acute intervention

----Patient was critically ill

Root: Primary emphasis on preserving life regardless of quality in US healthcare

NO DESIGNATED PHYSICIAN

Patient given CPR despite DNR status

-Delay in Code Status Conversation

--Multiple physicians saw patient (ED, GI, ICU, Anesthesia, OSH)

---Specialists often have separate code status discussions

Root: No designated physician who discusses code status with patient

CODE STATUS VIEWED DIFFERENTLY AMONG SPECIALTIES

Patient given CPR despite DNR status

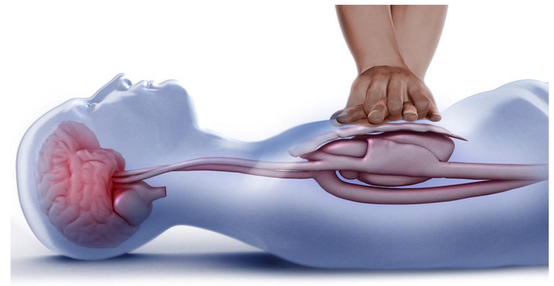
-Delay in Code Status Conversation

--Can be disagreement about utility of procedures

---Proceduralists will sometimes make patient full code for procedures

----Mortality data tracked during procedures

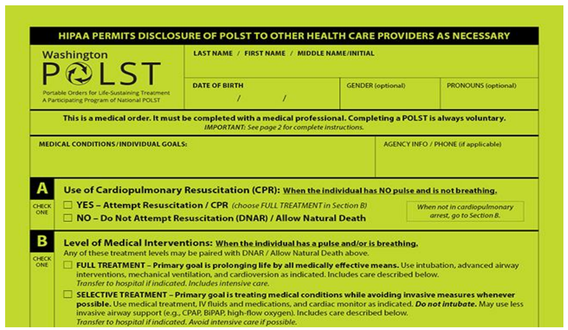
Root: Code status viewed differently between specialties



IMPROVEMENT

Possible methods to prevent similar event from happening again:

- Previous code status could auto-populate into EPIC
- Code status conversations could be initiated in the outpatient setting
- Code status could be incorporated into risk/benefit consent for procedures
- DNR bracelets on patients who are DNR earlier during admission phase
- Code status could be discussed in ED when critical care time is billed


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL

DATE OF BIRTH / / | GENDER (optional) | PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS: | AGENCY INFO / PHONE (if applicable)

A — Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.
CHECK ONE
☐ YES – Attempt Resuscitation / CPR (choose FULL TREATMENT in Section B)
☐ NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death
When not in cardiopulmonary arrest, go to Section B.

B — Level of Medical Interventions: When the individual has a pulse and/or is breathing.
Any of these treatment levels may be paired with DNAR / Allow Natural Death above.
CHECK ONE
☐ FULL TREATMENT – Primary goal is prolonging life by all medically effective means. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.
☐ SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.