WebM&M

Morbidity and Mortality Rounds on the Web

Spotlight

Code Status vs. Care Status

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

PSNet
PATIENT SAFETY NETWORK

Source and Credits

- This presentation is based on the December 2020 AHRQ WebM&M Spotlight Case
  - See the full article at https://psnet.ahrq.gov/webmm
  - CME credit is available
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- AHRQ WebM&M Editors in Chief: Patrick Romano, MD, MPH and Debra Bakerjian, PhD, APRN, RN
  - Spotlight Editors: John MacMillan, MD and Tammy Myers, MSN
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Objectives

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

- Articulate the difference between code status and a patient's goals of care.
- Differentiate between the four domains required for a patient to have capacity.
- Discuss how implicit bias and cognitive underspecification contribute to poor communication between care teams.
- Examine financial and policy-related pressures contributing to increased ICU and hospital bed turnover.
- Identify factors than can make someone a vulnerable patient in the context of healthcare; discuss possible interventions to better care for vulnerable patients.

CODE STATUS VS. CARE STATUS

A case describing how care inconsistent with patient goals can lead to preventable harm

Case Details

- 65-year-old African American man with metastatic squamous cell carcinoma was admitted to the hospital with a T10 burst fracture
  - Past medical history of schizophrenia, developmental delay (not conserved), and COPD
- Received neurosurgical treatment for the fracture but developed post-op complications (aspiration, respiratory failure, intubation, new deep vein thrombosis and pulmonary embolism)
- After extubation, he continued to require intermittent high flow oxygen or BIPAP to maintain oxygenation

Case Details

- Palliative care team consulted to discuss goals of care with the patient, particularly regarding further cancer treatment and the possibility of a permanent feeding tube
- Patient goal was to return home
  - Prior to admission, patient resided in a semi-permanent living facility, where he had a dedicated caregiver; he had no family involved in his life
- Decision was made to transition patient home with hospice care
  - Palliative care team and discharge planner worked with social services agency to coordinate the transfer home

Case Details

- Throughout hospitalization, the ICU team continued to optimize the patient's respiratory status
- On Friday afternoon, the care team felt that the patient would benefit from ICU care over the weekend to further improve his respiratory status and would likely go home the following week
  - However, within hours of changing the patient's code status to "Do Not Resuscitate" (DNR) and after the palliative care team had left for the day, the patient was transferred out of the ICU to the medical/surgical floor
  - The patient received a new care team and was not rounded on over the weekend. The team likely noted the patient's DNR code status and plan for home hospice care and felt no further interventions would be required

Case Details

- Outside of the ICU, the patient's respiratory status deteriorated over the weekend
- On Monday, the new medical team was unsure what to do about the patient's respiratory distress and called palliative care for clarification
  - Once the care team understood the intended care, they attempted to improve the patient's respiratory status with all measures short of intubation
  - They were unable to reverse the effect of the lack of care over the weekend and the patient did in the hospital later that week

CODE STATUS VS. CARE STATUS

THE COMMENTARY

By Rebecca K. Krisman, MD, MPH and Hannah Spero, MSN, APRN, NP-C

Background (1)

- The original care team worked with the patient, his caregiver (family surrogate) and social services to assess his goals for care, which were to shift the focus away from full cancer treatment to going home
- Because of the severity of his illness and need for around-the-clock nursing care at the time the decision was made to shift care goals from full cancer treatment to going home, the transition to home couldn’t be made right away.

Background (2)

- After the patient was mistakenly transferred out of the ICU, he became a victim of an alternate translation of the “Do Not Resuscitate” (DNR) order
  - According to The American Medical Association’s Council on Ethical and Judicial Affairs, *“DNR orders only preclude resuscitative efforts and should not influence other therapeutic interventions that may be appropriate*.”
  - Research shows that when a patient has a DNR order, not only do the attitudes of their physicians and nurses change, but actual care deteriorates as well (nurses call doctors less often, care is escalated less frequently)
  - Anchoring bias, or the tendency to rely too heavily on a single anchoring piece of information (in this case the DNR designation), can heavily influence the decisions of health care providers.

Understanding Capacity

Understanding Capacity (1)

- Although the original care team established that patient's capacity to make some (but not all) decisions about goals of care, the subsequent care team did not treat the patient as though he could make any decisions
  - When care team members see mental health diagnoses or developmental delay, they often question the patient's capacity.
  - In some circumstances, depending on the severity of the mental illness/episode or developmental delay, a patient may not be in a condition to make decisions about their care.
  - However, a diagnosis of developmental delay or mental illness alone do not speak to a patient's ability to weigh care decisions and reason through options to a final choice.

Understanding Capacity (2)

- The healthcare team must understand the components of decision-making capacity so that they do not deprive patients of their rights to make decisions about their care.
  - **Understanding** refers to one's ability to comprehend the information presented to them. After presenting information about a patient's condition and care choices, a provider should check the patient's understanding by asking them to explain what they have just heard in their own words. There may not be sufficient understanding if the patient repeats back word-for-word what the provider has said. Asking them to explain it in their own words demonstrates information processing by the patient to understand.
  - **Appreciation** involves the application of information presented to one's own situation. The patient must show how the information and choices relate to them personally. For example, a patient may demonstrate appreciation by verbalizing the consequences to themselves by forgoing certain treatments.

Understanding Capacity (3)

- Components of decision-making capacity, cont.
  - **Reasoning** refers to one's ability to compare the treatment options available and compare their risks and benefits in a logical, rational manner. Reasoning can be explored with a patient by asking open-ended questions about how they came to their decision or why they decided to forgo the options presented. It is important with this dimension to recognize that even if a patient's choice is not the one recommended by the care team, they can still have rational reasons specific to their own preferences for forgoing the recommended option.
  - **Expression of a Choice** is one's ability to convey a clear and consistent treatment choice. Patients still retain the right to change their mind. This dimension refers to the patient's ability to come to a conclusion about the information presented and express a clear choice based on that information and the other required dimensions of capacity.

Understanding Capacity (4)

- As demonstrated in this case, the patient's developmental delay and mental illness did not interfere with his capacity to make all decisions
  - His complex care plan required explicit communication with multiple parties to fully understand the patient's baseline and cognitive capabilities.
- **DNR code status does not mean that care stops for the patient.**
  - As he began to decline outside the ICU, he should have been offered information about BIPAP and other non-invasive treatment measures to improve his respiratory status so that he could fulfill his goal of returning home.

Communication Challenges

Cognitive Underspecification (1)

- When incomplete communication takes place or there is failure to have a shared mental model around the meaning of specific terminology, clinicians are prone to errors of cognitive underspecification.

- In this case, the ICU team had one idea about what the patient's goals of care were, and when the receiving team heard an abbreviated version of these goals, they filled in the gaps with their own understanding and experience. This process continued with handoff after handoff, and left the patient being lumped into a category of care that did not reflect his actual goals.

Cognitive Underspecification (2)

- For this patient, the goal was to return home
  - Therapies directed toward improving the patient's respiratory status would need to be continued.
  - However, if the mental model was that "home with hospice" meant "discontinue everything, except comfort focused treatment," the team did not recognize that in order to meet his goal, his respiratory status needed continued monitoring and intervention.
  - Further, the expectation of the ICU team was that his respiratory status would improve to the point where he could go home.

EHR, Burnout and Time Pressure (1)

- Clinical notes in the United States are four times longer than in other industrialized nations.
  - Spending time searching through the EHR for useful information contributes to health care worker fatigue and burnout.
  - The repurposed functionality of the EHR also leads to patient harm, as clinicians struggle to rapidly find the information they need to provide patient centered care.
- Workarounds to reduce EHR burden include:
  - Sign-out sheets, which are commonly used for handoffs and cross-coverage at night
  - Medical scribes and ancillary staff
  - Voice recognition software

EHR, Burnout and Time Pressure (2)

- EHR burden contributes to burnout
  - Burnout can lead to the depersonalization of patients, which seems to be evident in this case once he left the ICU
  - The repurposed functionality of the EHR also leads to patient harm, as clinicians struggle to rapidly find the information they need to provide patient centered care.
- EHR tools should facilitate communication between care providers and not overburden physicians.
  - Education and training, such as AHRQ's TeamSTEPPS (which focuses on teamwork and communication) counteract many of these patient safety risks.

Systemic Pressures on Patient Care

Pressures on Health Systems (1)

Healthcare systems face both financial and resource pressures

- The pressure to turnover hospital beds quickly increases the number of patients who move through the system, which supports hospital finances.
- Hospitals themselves – including staff, patient beds, and medical equipment – are limited resources.
  - Health systems endeavor to ensure an appropriate level of care for each patient; a patient with an uncomplicated dog bite does not need ICU-level care while a patient with respiratory failure needs care escalated beyond their primary care clinic.
  - Healthcare systems are encouraged to always be ready situations in which demand for hospital care might increase, such as a pandemic, a natural disaster, or a mass casualty event.

Pressures on Health Systems (2)

- In this case, the patient needed ICU-level care to support his respiratory status, but the weekend team likely felt pressure to move patients to lower levels of care in order to make room for other patients
  - Although his goal of care changed to reflect a supportive care focus, his original plan for discharge relied on continuing to receive intensive care
  - Hospital systems must work to strike a better balance between their systemic pressures and what is best for the care of individual patients

Pressures on Health Systems (3)

- In this case, the bedside staff caring for the patient did not receive adequate communication regarding the care plan
  - As hospital censuses increase and bedside staff take on more patients, a patient's perceived lack of needs may make them a lower priority
  - Had bedside medical/surgical or ICU nursing staff been made aware of the need for intense respiratory interventions to facilitate a discharge home, they may have more readily advocated for the patient to receive these measures of the weekend or even questioned his discharge from the ICU

Vulnerable Patients (1)

- Implicit bias may have impacted the clinicians that transferred this patient out of the ICU once the DNR status was ordered.
  - It is important to recognize the impact of implicit biases to ensure equitable, patient-centered care and begin to overcome the entrenched systemic racism in healthcare.
- The patient's vulnerable status was evidenced by his inability to advocate for himself
  - The palliative care team advocated for the patient by establishing a plan of care with the weekday ICU team, but once those services left, no one continued to advocate for this patient.
  - The patient's cognitive delay and schizophrenia, along with his declining respiratory status, made him unable to reach out for assistance for himself.

TAKE HOME POINTS

Take-Home Points (1)

- A patient with mental health conditions or developmental delay can still fulfill the four dimensions of capacity: Understanding, Appreciation, Reasoning, and Expression of a Choice.

- Care inconsistent with a patient's goals of care is a preventable harm. Patients at the end of life are often medically complex and their care may not become simpler when their goals no longer include cure or CPR. Becoming aware of the many biases we have and cognitive shortcuts we take can help us provide more comprehensive, patient centered care.

Take-Home Points (2)

- DNR is a code status. It should not determine how a patient is cared for, unless they have a cardiac arrest.
- Warm handoffs between providers, including consulting services such as palliative care, can improve communication and prevent avoidable errors.
- It is important for providers and other members of the healthcare team to be aware of their vulnerable patients and act as their advocates, especially when there is no family or other caregivers at the bedside.

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