Inpatient Basics – Code Status Discussions

- All admitted patients need a code status, but the emphasis you place on the code status and other goals of care discussion on admission will vary with the clinical situation.
- This topic is complicated and this guide is not meant to be exhaustive
- It's always a good idea to start with an opening line that normalizes and introduces this topic as something we talk about with everyone on admission.
- Fast Facts # 365 is another resource for these conversations. Some of their recs are slightly different than below, which is OK. (Google "Fast Facts Palliative Care")
    - The below framework was adapted from this resource

Discussion for young patients with a higher likelihood of success with CPR:

- "If your heart were to stop beating or you weren't able to breathe on your own, would you want us to do everything required to attempt to bring you back?" is a reasonable approach to discussions in these patients
- Further exploration can be done from there depending on clinical situation and answer.

Discussion for patients who would likely have a poor outcome if they were to have an in hospital cardiac arrest but who you do not expect to experience a cardiac arrest or other life-threatening emergency in the hospital:

- These patients are often elderly, frail, deconditioned, or have severe/multisystem disease
- The "everything possible" question above is not appropriate in this context
- You suspect that the outcome for this patient would likely be poor post cardiac arrest. They deserve to have information about this, tell them why. If you use the "everything possible" question, you leave that "everything" up to their imagination. Mostly this means you leave that interpretation up to whatever they've seen on TV, which we know is glorified compared to real life.
- In these situations, it is reasonable to discuss as two general options. You can say something like:
    - "We always ask everyone we admit to the hospital about they would want if their heart were to stop. I don't expect this to happen, but if it did, I'd want to be sure I was honoring your wishes. Is it OK if I explain a little more about what I mean when I talk about this subject?"
    - After consent: "When someone's heart stops in the hospital, there are two things that can happen next. The first option, is that someone gets CPR. This means that a team comes into the room, pushes on the person's chest which breaks ribs, places a breathing tube, applies electrical shocks, and puts them on artificial life support. If we are able to get the person's heartbeat back, then we take the person to the ICU where we hope they recover enough to be able to breathe on their own and think/recognize family members again. Though many patients on TV recover easily after these events, the true success rates are unfortunately quite low and if successful, there is a high likelihood of persistent disability and brain injury. The

second option is that some people feel that these actions sound painful and aggressive, and they feel that instead if their heart has stopped that means it is their time to die. They would want to be allowed to pass away peacefully. Do you have an idea about which of those options might be what you would want?"

- If the patient has questions about this topic that don't need to be answered this admission, this is a great time to refer them to their PCM or subspecialist post-admission to talk.

Discussion for severely ill patients for whom a poor outcome is likely (ie., ICU admissions)

- The goal of this conversation is to align the care we provide with their wishes while setting realistic expectations for outcomes after potential cardiac arrest
- This starts with determining what they already know about how severe their situation is, eliciting their values (what makes life worth living?), and determining what a fate worse than death would look like for them. With this information, we can explain the medical situation further and come together on a path forward (even making recommendations on things like code status in appropriate situations).
- SPIKES is a helpful mnemonic for this (see below, discuss how to operationalize with your seniors) and the Serious Illness Conversation Guide (can find this by searching online) has some great phrases that can be helpful

Setting

Perception

Invitation

Knowledge

Emotion (may use NURSE mnemonic →)

Summary

Naming

Understanding

Respect

Support

Explore

Remember: Discussing code status and goals of care is a PROCEDURE. You should watch someone else do one before you do one yourself. You should NOT go into your first goals of care conversation alone or unprepared. If you ever feel that you are being told to do these without adequate supervision or are put into positions where you feel that you're not the right person for this job at this time, please SAY SOMETHING. If your supervisor is not receptive to this feedback, please let program leadership know.