Goals of Care and Code Status discussions in the Emergency Department

About this guide:

- Sample conversations for scenarios frequently encountered in the emergency department (ED)
  - Talking to the substitute decision-maker (SDM) when Cardiopulmonary Resuscitation is in progress (CPR) and a poor outcome is anticipated
  - Goals of Care (GOC) Discussions for patients who are at risk of deteriorating in the ED
  - GOC discussions for stable patients requiring admission to hospital
- Adapt for local use: in some institutions ED physicians are responsible for admissions to hospital and may need to go further with these discussions than departments that refer for admission.
- Quick one-page reference (page 2)
- Steps to a GOC conversation (page 3)
- Algorithm (page 10)

Pointers for all conversations:

- Use simple, plain language and check-in frequently to ensure information is understood.
- Even though you want to get a decision about treatments, focus on the person, what's important to them and the outcomes with or without treatments (meeting the patient or Substitute-Decision Maker (SDM) where they are at, will facilitate faster decision-making)
- Avoid numbers or % - these are not meaningful to patients. Instead use ranges such as low, slight, medium and high chance.
- Cardiopulmonary Resuscitation (CPR) is a treatment that is only started AFTER the heart stops. Sometimes patients or families are afraid to accept a Do Not Resuscitate (DNR) code status because they worry, they will not receive as good care or no care. Provide re-assurance and explain what care you ARE offering before you tell them what treatments you are not offering.
- When talking about CPR, avoid focusing on chances the heart can be re-started. Try talking instead about chances of neurological recovery after CPR and what poor neurological recovery would look like in terms of function (being dependent for care, not recognizing family members, not being able to communicate etc.)
- Before you start the conversation, consider what recommendation you are prepared to make based on expected medical benefit of CPR. Adapt language as needed based on this assessment.
- Allow time (use pauses and silences) to let patients and SDMs express themselves
- Be ready to respond to emotions – don't give information in the face of strong emotions; support and wait until patient/SDM are ready to listen.

****When the patient comes with a level of care form or anything that says advance directive:**

- Don't assume these represent prior goals of care conversations.
- They are not informed consent for any treatment
- Avoid bringing them up too early in the GOC as they may bias healthcare providers and Substitute decision-makers and may hinder conversations.
- Allow the patient or SDM to bring them up. If they were written when the patient had capacity, they may be prior capable wishes
- Proceed with goals of care conversations as described below.

Return to page 1

Resuscitation in progress

Discussion with Patient or Substitute Decision-Maker

Prepare yourself to employ a ***modified breaking bad news conversation***
Explore illness understanding
Ask about the person and what is important to them
Ask about prior ACP discussions and wishes related to CPR
Emphasize the efforts that have been made to this point
Explain anticipated poor outcome from CPR
Relate poor outcomes to what is important to the person (e.g. pts ability to communicate)

Critically ill patient

May deteriorate in the ED or within 24-48 hours

i.e. need to address wishes about CPR, life sustaining treatments in the ED

Prepare. Consider if life sustaining treatments or CPR likely to have medical benefit
Explore patient/SDM illness understanding
Inform that patient is sick and may die; explain there are different treatment options and need to have short discussion to help decide what is best for patient
Ask about previous ACP discussions and wishes related to CPR

- **YES, wishes were expressed and does not want CPR/life sustaining treatments:** review and confirm or discuss any changes; document
- **No expressed wishes**:
  - **Explore** values, goals and what's important to the person
  - **Explain** CPR and life sustaining treatments given serious illness. Focus on outcomes that are important to patient
  - **Identify** patients who wish to avoid life sustaining treatments and document
  - For all others, **make recommendation** based on (1) clinical assessment of effectiveness of life sustaining treatments (LST) AND (2) patient's values and goals.
    - **If LST likely effective**: recommend specific treatments
    - **If uncertain if LST effective**: present options of (1) maximizing medical interventions and if condition does worsen focus on comfort or (2) maximizing medical interventions and if worsens, trial of specific LST
    - **Ineffective**: Make recommendation that if condition worsens, focus on comfort and avoid treatments that won't benefit

Stable admitted patient

Not expected to deteriorate in the ED or next 48 hours

i.e. there will be time for the inpatient team to address goals of care in a less acute setting

Explore illness understanding during initial history taking, so you are aware of what the patient/SDM understands
Explain treatments you are recommending in the ED or for this admission
Ask about any previous ACP discussions and wishes related to CPR:

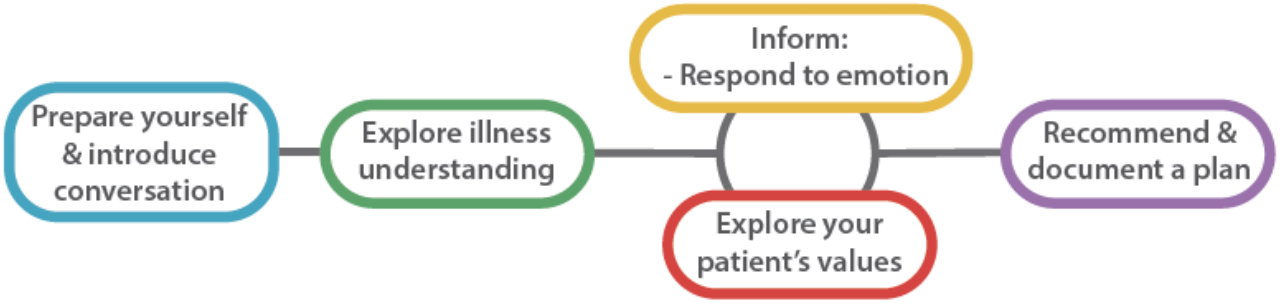
- **YES, and does not want CPR/life sustaining treatments:** review and confirm or discuss any changes; document
- **NO** or wishes FULL code and this may not be consistent with expected medical benefit from critical care interventions.
- Set the stage for further discussions with the inpatient team
- If appropriate, offer information about the progressive nature of underlying illnesses (e.g. dementia, COPD, CHF, malignancy)

**N.B. If the patient is stable, consider that the ED may not be the appropriate environment (chaotic, loud, patient or SDM under stress) to have a full goals of care

Return to page 1

Goals of Care and Code Status discussions in the Emergency Department

A conversation guide to align available treatment and care options with the patient's goals and values.



Steps:	Phrases:
PREPARE YOURSELF & INTRODUCE CONVERSATION: • Know clinical status • Know treatment options • Leave your agenda aside so you can really listen	"I'd like to make sure you get the best care possible. To do this, we need to have a serious conversation."
EXPLORE ILLNESS UNDERSTANDING: • Listen and clarify with questions	"Tell me what you know about what has happened so far... Tell me what you know about what brought him to the hospital."
INFORM: • Fill in any information gaps: be clear • Speak slowly • Pause often to let information get absorbed • Expect & respond to emotion with empathetic statements	"Despite giving your father oxygen, his lungs are getting worse...this makes me concerned that he may die from this infection." • "This must be shocking news...." • "I can hear how upset you are..." • "Tell me more about...."
EXPLORE YOUR PATIENT'S VALUES: • Ask about: • Goals and values • Hopes, fears and worries	"I wish it were different...I am worried about him...I wonder if he ever talked about how he would want to be cared if he were critically ill...." • "Do you have any worries or fears for him at this time? • "What do you think he would say would be most important to him at this time?"
RECOMMEND & DOCUMENT A PLAN: • Based on your clinical assessment AND patient goals, recommend a treatment plan • "Given what you've said and what I know about his medical situation, I'd recommend"	"You've said his goal is to live long enough to see his brother who is coming to visit from overseas"... "I think we can work together on that. I'd suggest we..." • "I'd like to recommend that we use medications and oxygen to try and help him recover but, if he continues to get worse, that we focus on comfort instead of prolonging this time with life support measures... • "Your goal is to focus on comfort and being near family ... in that case, I'd recommend..."

Additional COVID-19-related communication skills (free access): https://www.vitaltalk.org/guides/covid-19-communication-skills/

Acknowledgement: Ariadne Labs' *Serious Illness Conversation Guide and VitalTalk* were used in developing both the structure and content.

When CPR is in progress but based on the situation, the person is not likely to survive or would have a poor neurological outcome:

- Although consent is not required to stop a resuscitative effort, having families and SDMs in agreement with the plan is preferable.

Ask about the condition that led to the arrest and determine understanding of underlying illnesses:

Can you tell me what you know about your mom's conditions? I want to understand who she is and what her health was like before she collapsed.

If patient was "healthy" prior to arrest

I can see why this might be such a shock to you. She seemed fine one minute and now we are here in the ER working very hard to try and re-start her heart. It has now been x amount of time and despite our best efforts her heart isn't responding. At this point even if we were able to get it re-started, her brain has been without oxygen for a long time. You mentioned that your mom was healthy and living independently before this happened. After this long without oxygen, it's highly unlikely that she would be able to do any of that.

Pause…and then say: *Given all this, I am suggesting that we stop CPR/resuscitation.*

If patient had chronic illnesses prior to arrest

Thank you for giving me an update of what your mom's health has been like these last few days. It sounds like she has been slowly getting worse over time. When someone has diabetes and heart disease like your mom, their body and heart get weaker over time. Unfortunately, those conditions also mean that the chest compressions and medications that we have been trying for the last X minutes/hrs are less likely to restart her heart. Her heart is too weak to respond to these treatments. At this point even if we were able to get it re-started, her brain has been without oxygen for a long time. You mentioned that your mom has been progressively slower and weaker lately. After this long without oxygen to her brain and other organs won't survive. I am suggesting we stop using CPR now as your Mother has died and continuing to use CPR is not going to help.

Critically ill patient who may deteriorate in the ED or within the first 24-48 hours of admission

- You need to deliver information about a serious medical condition and get a preference about CPR and/or life sustaining treatment (intubation, vasopressors, etc.) in a short period of time.
- In this situation – do a quick check in about what they know about their illness and then move onto giving information.

Return to page 1

Prepare:

- Consider the patient's condition and whether CPR or life sustaining treatments might be of medical benefit
- Focus on medical facts only and recognize that patient values and perceptions of outcomes may vary – you will learn what the patient values through the GOC conversation.

Introducing the conversation and asking about illness understating:

I see from your medical record/what you've told me, that you have CHF (dementia, cancer, COPD). Can you tell me what you know about it? Things such as how bad is it? Has it been getting worse? How does it affect your life on a day-to-day basis?

- Gently correct misconceptions as needed. Then give an update on what's happening today that has led to them being so sick.

Unfortunately, people with COPD can get sicker when they pick up even the common cold. Because their lungs are weakened by the COPD, it is a lot harder for them to get better. And even when they do recover from each exacerbation, their lungs are a little weaker each time. That is what has been happening to you and today things are quite serious. From what you told me, I understand that you have been sick before and managed to recover, but I worry that this time may be different because the disease has gotten worse.

I know I just delivered a lot of information in a short time and it can be a lot to absorb. I would normally like to take more time, but you are very sick, and we need to make some decisions soon. Do you have any questions about what I just told you?

Pause and give them a time to absorb what you have told them.

Before I start to make recommendations about treatment options, I want to ask if you have ever thought about situations like this and the kind of care you might want?

Responding to those who have thought about it and do not want CPR or any life sustaining treatments:

- Confirm these wishes and what that will mean in this case.
- Offer medical and symptom management appropriate to the condition. Document code status and preferences for life sustaining treatment.

Responding to those who have thought about it and want CPR and/or life sustaining treatments:

- If this fits with your medical assessment, document Full code and discuss specific life sustaining treatments and ask for consent.
- If this does not fit with your medical assessment, revisit illness understanding, assess values and goals and see Page 4 "making a recommendation for a DNR Code Status"

Return to page 1

Responding to those who haven't thought about it, asking about values and goals:

That's ok. First, will you tell me a bit about yourself? What are the most important things about your health and your life that make it meaningful for you?

- ***Relationships*** *– friends, family etc. And what about that relationship is important? Communication with them etc.?*
- ***Emotions*** *– pride, joy, sense of accomplishment or legacy, comfort*
- ***Maintain physical or mental activities*** *– follow this up with why those abilities are important to maintaining quality of life*

- Actively listen and consider how you might apply this information to the context of the current illness and possible treatments

e.g. CPR – poor neurologic outcome may impact independence or ability to communicate and recognize family

e.g. Intubation – may risk side effects and potential for poor outcomes if there is a chance could recover one more time to make it to important life event (birth of a grandchild, wedding etc)

Explain the treatment of CPR:

- focus outcomes based on the values and priorities you have learned about the patient

There is a combination of treatments, called CPR, we can try after a person's heart has stopped. This usually involves a pushing on the chest over the heart and/or using electrical shocks. Sometimes it can involve putting a breathing tube into the throat. When a young healthy person's heart stops these treatments can sometimes be successful but not all the time. As a person gets older and develops more serious medical problems, such as heart or lung problems (include any conditions the person may have), CPR is even less successful. If a person with these conditions gets sick enough for their heart or breathing to stop, there is a very low chance that these treatments will work. Even if they do work in those few cases, the person may have worsening disabilities because the brain didn't get enough oxygen during CPR. In those cases, CPR only prolongs the inevitable, sometimes for hours, or days depending on the circumstances. These people may not be able to come off a breathing machine or they may not be able to communicate, or they may be dependent for a lot of their care

Making a recommendation for a DNR Code Status:

Based on my medical assessment so far, I am recommending that we do... This treatment/approach will treat your condition (e.g. pneumonia, or whatever other condition they are requiring admission for). This is the most appropriate treatment for your condition right now. However, if this doesn't work and your condition continues to deteriorate despite this medical care, what I would recommend is that we use all the treatments and medications that we need, such as oxygen as you need it, medications for pain or difficulty breathing, to keep you comfortable.

Return to page 1

I would also recommend that, we don't use techniques like CPR and breathing machines to prolong this phase. We know they aren't effective to help you recover and they only increase suffering and prolong this time. Does this sound reasonable?

When a patient or SDM is asking for CPR or intubation and medical benefit is unlikely. (e.g. when they ask for "everything"):

- The goal is to explore the reasons for the request.
- Attempt to find treatment options that can help them achieve goals even if not intubation or FULL code status.
- It may be reasonable to offer a trial of treatment (intubation, other etc.).
- It might be reasonable to offer a trial of intubation, non-invasive ventilation etc. but no CPR if the heart stops.

When you say you/they want everything, what does that mean? Can we take a moment to talk about what's most important to you right now?

Thank you for sharing that with me. From what I am hearing, it sounds like being able to communicate with your family and……. Are very important to you. I can see why you want us to "do everything". Let me tell you what we can offer to try and help you reach those goals (list the treatments, plans etc). Those are the best options to treat your condition. Sometimes things get worse, despite all the treatments we try, in that case, I am recommending that we do everything to keep you comfortable but that once your heart stops or you stop breathing, we don't intervene. Does that sound reasonable?

DNR recommendations:

I understand that you may not agree with this recommendation, but I CPR is not likely to be of any medical benefit to you and may even prolong suffering. It will not treat your condition and if you get sick enough for your heart to stop it has an even lower change of being successful.

Most people who have conditions like yours do not survive even with CPR, and even in those very few where we can restart the heart, unfortunately it has a high chance of stopping again. Or they need a lot of care afterwards and sometimes cannot come off a breathing machine for a long time. You mentioned that …….is important to you. I am not sure that CPR will help you reach that goal and I worry that you might end up in a worse situation.

Intubation/mechanical ventilation:

I understand that you are hopeful that putting in a breathing tube might help you recover. I am worried that if we go down that path it might be difficult for you to come off the ventilator, especially in your weakened condition. When people have a breathing tube, it can often be quite uncomfortable, so we have to use heavy sedatives to keep people asleep or unconscious. This means that while you are on the breathing machine, you probably won't be able to communicate. I am also not sure that a breathing machine is going to help you get better. My recommendation based on your current situation is medical treatment, with medications and oxygen to help with the shortness of breath.

Return to page 1

If they still prefer intubation and medical benefit is unlikely but still possible

Based on your condition, improvement with a breathing machine is not very likely but I do understand that trying is important to you. How about we try it for a few days to see if there is any improvement? If there is no improvement or if your condition continues to get worse, you will be given medications to keep you comfortable and the breathing machine will be stopped.

The "stable" patients with serious underlying illness or clinical frailty who require admission (unlikely to require resuscitation while in the ER or within 24-48 hours of admission):

Illness understanding:

- Explore as part of regular assessment of past medical history
- Often there is a disconnect between what patients have been told and what they understand.

Can you tell me about your heart failure? What has your cardiologist told you to expect?

Introduction to the conversation and asking about previous discussions:

Based on the what's going on today I think you need to be admitted to hospital for treatment. (explain the treatments) I expect you to recover with these treatments. However, we do know that sometimes people with serious illnesses can get sicker.

Pause and follow up on response to patient being told they have a serious illness. It they seem surprised, offer to discuss their underlying medical condition to give them more information. If they aren't ready, document this so that it can be followed up during or after admission.

Because of that, we ask all patients some questions about what would be important to them if they were to become very sick in the future. Many people like yourself have given this some thought … some have discussed this with their family, their other doctors, or friends. We call this advance care planning….

Have you ever thought about or had any conversations with family, friends or others about how you want your care to go in the future if you were to get very sick?

Some may need a more specific prompt:

The reason I am asking is that whenever someone comes into the hospital, we want to make sure we know if there are kinds of treatments they wouldn't want to happen, and some people have already thought about that….

- Based on how they respond, you might not need to discuss CPR – they may have given you clear direction to use medical management and avoid CPR. Confirm and then document.

Return to page 1

If they haven't heard at all about ACP, or never thought about future care

- Use your clinical judgement on how likely they are to either deteriorate during this admission or in the next 6 mo-1yr.
- If healthy and low risk for deterioration, assume full code status unless they indicate otherwise.
- If one or more serious chronic illnesses or frailty, use this opportunity to start to introduce the concept of Advance Care Planning and address illness understanding.

Pause and reflect:

- Is the person/SDM ready to have this conversation now? (adequate illness understanding, middle of the night, chaotic ED)
- If it's not the right time and there is low risk of deterioration or urgency to know the code status, consider deferring the conversation till the patient is on the ward.

Deferring the conversation until the next day or to the admitting team

Once you are admitted, and have had some time to think about things, this will be discussed again. For now, think about any questions you might have about your health and illness that they can answer for you.

For those who do want to have the conversation now (or for use by admitting team)

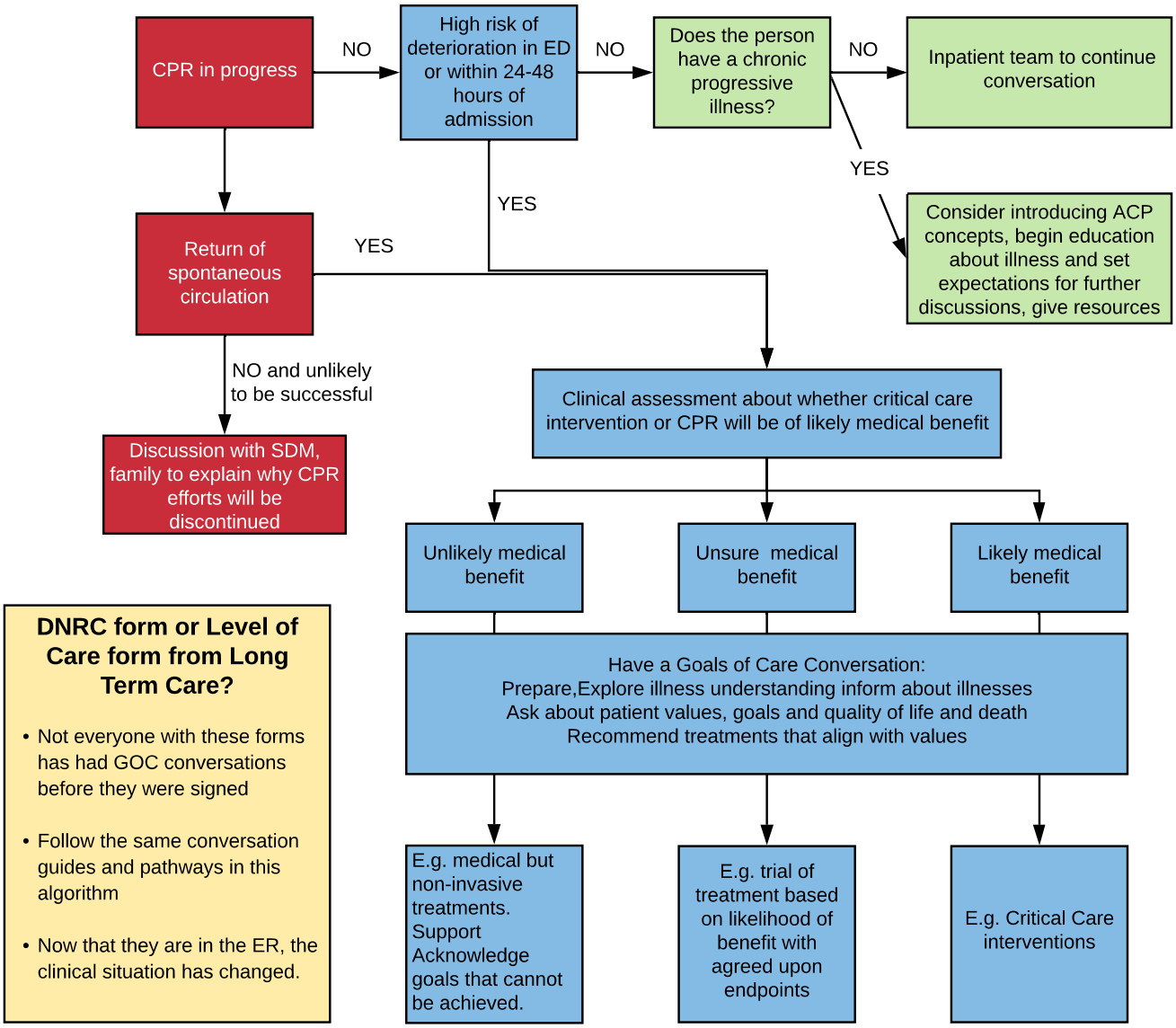
See section in the guide (page 3) "Responding to those who haven't thought about it, asking about values and goals" but it is ok to keep a hopeful/hypothetical tone with the patient/SDM because these are not patients who are expected to deteriorate.

For almost all treatments, we will have time to talk about them if you needed, explain them to you, but there is one that we need to talk about in advance because if something happens suddenly, we won't be able to talk first….

Again, I don't expect this to happen to you…it is just that it is helpful to think about it well in advance…

Return to page 1

GOC discussion around CPR and Life Sustaining Treatments in the Emergency Department



DNRC form or Level of Care form from Long Term Care?

- Not everyone with these forms has had GOC conversations before they were signed
- Follow the same conversation guides and pathways in this algorithm
- Now that they are in the ER, the clinical situation has changed.

Return to page 1