

Code Status Limitations

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WHAT DO WE DO when a patient with a do not resuscitate (DNR) order comes into our care for a palliative care procedure? Do we simply ignore it until the procedure has been completed? Do we avoid any attempts to intubate the patient who unexpectedly becomes oversedated and hypoxic? Physicians and researchers from two American academic hospitals explored current adoption of standing guidelines for situations like this.

A Pilot Study to Evaluate Compliance with Guidelines for Preprocedural Reconsideration of Code Status Limitations. Urman, R.D.; Lilley, E.J.; Changala, M.; Lindvall, C.; Hepner, D.L.; and Bader, A.M. *Journal of Palliative Medicine*. Volume 21, pp. 1152-1156, 2018. DOI: [10.1089/jpm.2017.0601](https://doi.org/10.1089/jpm.2017.0601).

Background and Purpose

As health care improves and expands its treatment options for patients with terminal disease, such as pancreatic or ovarian cancer, questions surrounding how to handle DNR or do not intubate (DNI) orders arise as patients receive palliative care options. A particular example is the placement of a venting gastrostomy tube (VGT) for bowel obstruction.

The Association of Perioperative Registered Nurses, the American College of Surgeons, and the American Society of Anesthesiologists endorse the following guidelines: Patients must be involved in the decision-making regarding code status. Therefore, providers should discuss code status

limitations (CSL) in the context of any particular procedural risk and confirm, suspend, or modify the existing CSL. Documentation of CSL, the discussion with the patient, and the postprocedure plan for CSL are essential for compliance.

The purpose of this pilot study was to identify the rate of compliance with standard guidelines of CSLs for patients undergoing VGT placement for bowel obstruction.

Methodology

After human subjects review and approval, researchers collected data retrospectively from the Research Patient Data Registry, which included patient encounters from two different hospitals. All patients who underwent VGT placement in 2014 and 2015 were targeted for inclusion. A total of 53 patients were identified.

Based on code status, patients were categorized as full code (no DNR or DNI order) or CSL (existing DNR or DNI order). For those categorized as CSL, records were reviewed for the following: 1) code status discussion (CSD) in which notes reflected a conversation between patient and provider regarding the risks of the VGT placement and 2) documentation of a plan to reinstate CSLs after the VGT placement. Researchers recorded the presence or absence of these variables for all 53 patients.

Results

During 2014 and 2015, 53 patients, mainly female (68%) with a mean age of 61 years, underwent VGT placement for bowel obstruction secondary to malignancy. Providers were grouped as interventional radiologists (88%), anesthesiologists (23%), surgeons (10%), and gastroenterologists (2%). Twenty-three (43%) of the sample had a documented CSL.

Of those 23 individuals, only five (22%) had a documented discussion with a provider, whereas 18 (78%) had no discussion documented before

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the procedure. Two of the five patients who had a CSD had no change in CSL, but three had a modified code status after the CSD. Of those, only one (4%) had a documented plan to reinstate the CSL after procedure. Therefore, a total of three patients were deemed compliant with guidelines for CSLs in this study.

Conclusions

Documentation for patients with terminal disease and undergoing VGT placement as a palliative measure reflected poor compliance with professional guidelines. More than two-thirds lacked the required CSD, and 40% of those with documentation were incomplete. These findings were consistent with similar studies investigating DNR orders and documentation of discussions with patients preoperatively. With the increasing frequency of palliative procedures, all providers need to be prepared to discuss and document the patient's desires regarding resuscitative efforts. Moreover, the Joint Commission and other professional organizations need to offer broader standards for DNR management to support hospitals, providers, and patients.

PeriAnesthesia Nursing Implications

Perianesthesia nurses work in procedural settings all over the world. Whether as the sedation nurse

or one of several providers caring for patients with CSLs, the perianesthesia nurse should be prepared to manage these patients' needs. In addition to direct care, perianesthesia nurses as members of hospital committees and specialist organizations can be the voice to bring this issue to the forefront.

Nurses play a key role in assuring patients, full opportunity to make informed decisions, and code status during a procedure is no different. Once compliance guidelines are in place—from national accrediting agencies to individual hospitals—provider education will be ongoing. Perhaps, the electronic health records can offer mechanisms for assuring these critical discussions take place and get documented.

Importantly, the American Society of PeriAnesthesia Nurses initially addressed this issue in 1996 and most recently revised the position statement in 2015.¹ Their promotion of specific instructions for members is commendable and delivers instructions consistent with those cited in this article. As ASPAN clearly detailed, we are the providers who interact with these patients and have integral connections with other providers. Most importantly, our ethical duty as patient advocates demands we take action. Let us all make sure we are consistently following our principles.

Reference

1. American Society of PeriAnesthesia Nurses. Position statement 1: A position statement on the perianesthesia patient

with a do-not-resuscitate advance directive. Available at: <http://www.aspan.org/Clinical-Practice/Position-Statements>; 2019. Accessed February 27, 2019.

Erratum



In the continuing education article, "Pediatric Emergence Delirium: A Case Study," (2019;34:469-475), the third author's name should be spelled Michael McLaughlin.