Cracking the Code: Hospital-Specific Resuscitation Outcomes and Code Status Discussions

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### Background

Evidence suggests that, across the country, code-status decisions are informed by neither national-scale nor hospital-specific data on resuscitation outcomes. Moreover, additional studies have shown that patients routinely overestimate the odds that a resuscitated patient will survive to hospital discharge. This is concerning, because the higher a patient’s perceived odds of surviving until discharge, the higher their likelihood of electing full-code status. Therefore, it is reasonable to conclude that patients’ code-status decisions are not ideally informed without a discussion of post-resuscitation outcomes.

### Methods

Mixed methods. Data regarding the content of code-status discussions was collected via survey. The instrument used in the study contained 6 items, and responses were confined to a 4 point Likert scale to reduce central tendency bias. The instrument was pilot-tested with 3 other reviewers to establish content validity. Outcome data was acquired via retrospective chart review of patients resuscitated over the last 3 months of available data (4/2015-6/2015).

### Results

30 surveys were completed out of a total 71 surveys (42%). Of respondents, over half of respondents (60%) indicated that they discussed post-resuscitation outcomes during their code-status conversations at least most of the time. Less than a quarter (20%) always discussed post-resuscitation outcomes. The most commonly discussed outcome was mortality (25—83%), while 17 respondents (57%) indicated that they discussed both cognitive/psychological outcomes and/or “other physical or disease specific morbidity”. Regarding their use of statistics, 18 respondents (60%) either never employed statistics in these discussions or did not discuss post-resuscitation outcomes. Of the respondents who indicated that they employed statistics, most cited a national scale study (7 = 58%). Interns were less likely to discuss outcomes other than mortality (2/11 = 18%) than older residents (14/18 = 78%). Both residents (8/18 = 44%) and interns (4/11 = 36%) were equally likely to use statistics when discussing post-resuscitation outcomes.

### Conclusion

Post-resuscitation outcomes specific to this hospital were similar to the national average. Among the members of the internal medicine residency at LVHN, the frequency with which post-resuscitation outcomes are included in code-status discussions remains sub-optimal. Residents are more likely to reference mortality than other harms during these discussions, especially among interns. Timeframes of the outcomes discussed by residents tended to be short term rather than long term. Statistics about post-resuscitation outcomes are under-utilized by some residents at LVHN.