

# Improving the process for capturing Resuscitation Status & Discussion

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## Introduction/Background

End of life care is a very sensitive topic. Clarity in the capture and communication of advance directives is crucial. The former process for capturing this information was disjointed and lacked the detail around those items so personal to the individual. The process included an order for status, a form that would be filled out with basic information about what should/shouldn't be performed and an unstructured note to capture some details about the discussion. This was problematic because not all of the information was properly housed in one place.

## Methods

Through many design sessions, the team constructed a new process which would allow for any clinician to document the information that the patient/family presents. This information is broken down into three sections:

Details of the status: Broadening the availability of items pertinent to the resuscitation status; Dialysis, artificial nutrition and artificial hydration have been added to the options, in addition to fields which allow for the patient/family to specify wishes that might not be part of the standard options.

Discussion: Replacing the separate note option, this section drives the user to document not only the details of the discussion, but also the participants in the discussion (which wasn't always captured previously). The addition of a field for MOLST (Massachusetts Orders for Life Sustaining Treatment) allows documentation of whether the patient has orders outside of the institution.

Removal: A special section which allows for documentation of status to be removed from the chart (alerts no longer appear) if and when the condition of the patient changes and they no longer want/need the status that was documented.

Further improving the process, the indicators for the status are presented to the end user at the time of entering the patient chart. They are also available on a special patient information page, and in a structured text document within the patient notes folder.

## Results

Feedback from end users has highlighted that this new process has allowed for a more streamlined process for all users to be able to assist in a very sensitive time in the patient care experience.

## Discussion/Conclusion

Most people want their wishes about end of life care to be clear and well known by those providing care to them.<sup>1</sup> This new system of capturing the information helps to ensure that the information is appropriately captured and presented to the end user, satisfying both of these requirements.

## References:

1. Non-interoperable directives: End-of-life wishes and EHRs don't yet mesh  
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