To Resuscitate
Or Not to Resuscitate?

Coping with Changing Admission Criteria
at St. Paul's Palliative Care Unit

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History

Introduction

• Who knows what CPR is?
• Who knows what a “full code” is?
• Who knows what palliative care is?

Background

• Brief history of palliative care and CPR
• What happens when “palliative” meets CPR?
• How do staff process change in practice?
Context

• Spring 2009
  – 4 Full Code admissions to St. Paul’s PCU—unplanned

• Climate of tension, uncertainty
  – Are we changing admission criteria for PCU?
  – Does this fit with philosophy of Palliative Care?

• To cope with change, 2 staff meetings facilitated by Change Initiatives

• Impetus for this project
Purpose

• Understand the process of development of best practice for admission of full code patients to St. Paul's Palliative Care Unit (PCU)
# Program Description

## Logic Model

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<th>Inputs</th>
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<th>Participation</th>
<th>Short Term Changes We Expect</th>
<th>Medium Term Changes We Expect</th>
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<td>What we invest</td>
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<td>Medium term changes we expect</td>
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<tr>
<td>• Time, Energy, Experience, Evidence base, PCU staff expertise, Interest/curiosity, Goal to provide high quality patient care in the context of a safe and satisfying workplace, Patients’ &amp; families’ experience and perspective</td>
<td>• Learn new knowledge base &amp; skills to evaluate program, Create evaluation tool, Literature search, Use experiences of PCU from January 2008 to June 2009, Questionnaire and focus groups to collect information, Take all discussion materials and create Exceptions to Admission Guidelines, Facilitate communication within all PCU staff</td>
<td>• PCU staff, Staff across PHC, Operational staff, Patients &amp; families, Anyone who regularly interfaces with PCU for patient transfer (BCCA, community health), Potentially international Palliative Care community &amp; related professions</td>
<td>• Formalize “Admitting by Exception Guidelines”, Accountability for decision-making with respect to accepting Full Code patients, Promotion of discussion regarding clearly determining Goals of Care and the palliative care approach</td>
<td>• Use of these guidelines by all staff and feedback, Build capacity &amp; empowerment within PCU staff—able to suggest feedback and internally evaluate, Increased clarity of goals of care, Increased clarity of the scope of PCU at St. Paul’s (strengths, weaknesses, limitations), Redefine Vision Statement of PCU with staff input</td>
<td>• Influence policy change with evidence and staff feedback</td>
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**Assumptions**
1. “Admission By Exception Guidelines” is an adequate tool to address Full Code patient issues
2. All PCU staff will participate in process (including those who are resistant to shift in caring for patients earlier in disease trajectory)

**External Factors**
1. Staff participation
2. Patient & family participation
Methodology

Questions focused on staff concerns, what helped/did not help, institution help, personal responses

**Qualitative**
- 9 taped interviews
- 1 written interview
- Digital recorder
- Transcriber processed data
- Evaluators analyzed data looking for common themes

**Quantitative**
- Anonymous questionnaire
- Offered to all staff
- Self selected group
- 8/25 completed and returned questionnaire
- Likert scale and Excel spreadsheet represented data
Limitations

Qualitative
- Time
  * Logistics of researchers (3)
- Accessibility of staff
- Acuity of the unit
- Shift work
- Winter Olympics
- Interest of participants
  * Long time passed since issue arose

Quantitative
- Time
- Interest of participants
- Retrieving completed questionnaires
- Self selected group bias
Qualitative Findings

What we did right...

• 2 Change Initiative meetings summer 2009
• Peer discussions
• Multidisciplinary team discussion
• Observation by staff that since the open discussions no Full Code pts. have been admitted to the PCU
Qualitative Findings

Challenges of accepting Full Code Pts.

• Direction of patient care – what is goal of care?
• Direction of Palliative Care – what is goal of care?
• Performing CPR
• Top down approach
• Limited Full Code patient admissions
• The unit is changing
• Ethical issues
• Stress on unit in presence of Full Code patients
Qualitative Findings

Supports

• Varied responses
• 2 Change Initiative Meetings, summer ’09, positive experience
• 3/9 interviewees did not feel supported by staff as change took place
• More education needed on performing CPR
• Discussions between Dr’s and RNs re full code pts need to occur during admission process
• Interviewees want to know if decision made re: Full Code patients
Quantitative Findings

Highlights

• Most neutral/agreed that Full Code Pts should be admitted to PCU
• 1 Interviewee did not believe Full Code Pts should be admitted to PCU
• Most agreed that the meetings were helpful
• Most neutral/agreed that concerns were acknowledged but most also felt concerns were not acted upon
• Most did not know outcome of meetings and did not feel results were well communicated
Discussion

- Both qualitative & quantitative results = mixed reviews
- Recurrent theme in qualitative interviews = reflection about effectiveness of Palliative Care approach for Full Code patients
- Cannot interview patients and families limiting a broader discussion
- Were Research Participants too close to issue?
- Literature supporting “Change” in Policy re Code Status is limited
- Vancouver Coastal Palliative Policy, re code status, discussed after issue of Full Code patients
Recommendations

• **Immediate:**
  – Communicate summary of discussions from meetings
  – Evaluate quality of care / workplace satisfaction after the admission of 4 Full Code patients

• **For future policy changes:**
  – Advance warning and discussion
  – Provide forum for as many staff as possible to share concerns / have discussion / reach group consensus
  – Educational opportunities to prepare for change
  – Ensure information is widely available to all staff members
What We Learned

• Evaluation is invaluable way to measure effectiveness and adherence to goals
• Fine art in crafting evaluation question and appropriate data collection
• Practical limitations and challenges of evaluation
• Communication is key
• This topic is bigger than this Evaluation Project therefore requires further exploration
Summary

• Medicalization of dying, changes in Palliative Care
• This project is a symptom of a greater issue, “Pathology of Denial”
• Are we in Palliative Care unwilling to address what others before us have been unwilling to talk about?
• We’re all going to die and we need to talk about it
Thank You

• Michael Smith Foundation
• Change Initiative Team, SPH
• Our Cohort group for feedback
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