The Results and Impact of a Death Chart Audit in an Academic Health Care System

2018 National Share the Experience
Quality improvement/Research – ACP/SDM and measuring the quadruple aim

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Honoring Care Decisions, DHMC
Independent Contractor, Respecting Choices
According to this study, the germiest place in the kitchen is the vegetable drawer.

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Can you believe that?

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Learning Outcomes:

1. Perform a death chart audit to identify and improve person-centered advance care planning outcomes.
2. Understand the results and impact of a death chart audit tool in a large health system with the intent of improving person-centered policy, procedure and educational opportunities for providers and staff.
What I will talk about:

- About DHMC, HCD, New Hampshire, Geisel School of Medicine, TDI
- 2015 Death Chart Audit tool, findings, early impact
- 2017 Death Chart Audit, impact and implementation planning
- Lessons Learned
Honoring Care Decisions

Who would speak for you if you were unable to speak for yourself?
“...death is not the worst of evils...”
General John Stark, 1789
I. Subject to the provisions of this chapter and any express limitations set forth by the principal in an advance directive, the agent shall have the authority to make any and all health care decisions on the principal's behalf that the principal could make.

II. An agent's or surrogate's authority under an advance directive shall be in effect only when the principal lacks capacity to make health care decisions, as certified in writing by the principal's attending physician or APRN, and filed with the name of the agent or surrogate in the principal's medical record. When and if the principal regains capacity to make health care decisions, such event shall be certified in writing by the principal's attending physician or APRN, noted in the principal's medical record, the agent's or surrogate's authority shall terminate, and the authority to make health care decisions shall revert to the principal.
Internal Mock Audit based on Joint Commission Criteria:
- Scoring Category: C
- Score: Insufficient Compliance

- Staff were unaware if patient had an advance directive and staff didn’t know where to find it

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Death Chart Audit, 2015

- 4th Year Medical Students: Health Society and Profession Course, Geisel School of Medicine at Dartmouth
- 80 randomly selected charts of deceased patients at DHMC

Death Chart Audit Tool

- Patient ID (MRN, gender, DOB, age, PCP)
- Hospital admission (LOS, point of origin or transfer, admission service/department)
- Discharge diagnosis
- Capacity/incapacity documentation
- Advance Directive (on admission, at death, validity)
- AD: Life Sustaining Treatment (if near death, if permanently unconscious, honored or care consistent with preferences)
- Decisions made by legally documented decision maker
- DNR orders (presence of Portable DNR, use of CPR concordance with preferences)
- POLST in EMR (CPR/DNR, Medical Intervention, Artificial Hydration, Antibiotics) and concordance with orders/preferences
- Comments
Methodology

• **Mortality Audit Tool:**
• Was care consistent with patient preferences?
  • **Yes:** Had AD/DPOA and were followed, patient directly involved, OR family made reference to specific conversation had with patient
  • **No:** Care went against AD or patient preferences
  • **Unclear:** Didn’t have AD or DPOA or patient wishes unknown

Issue 1: Lack of Advance Directives

• 46 patients (57%) did not have AD in record
• Are people who pass away quickly less likely to have AD in the record?
  • 10 out of 16 ppl (62%) LOS 0-1 days did **not** have AD
  • 35 out of 64 ppl (54%) LOS 2+ days did **not** have AD
• 15% (n=12) patient with POLSTs/COLSTs
• 7.5% (n=6) patient with P-DNRs
• **Preferences honored 100% of time for patients with POLSTs/COLSTs**
Issue 2: Documentation of Loss of Capacity

• Recall NH Law and DHMC policy: “patient’s Attending Physician or APRN will document...written verification of the patient’s lack of Capacity to make healthcare decisions triggers the Agent’s or Surrogate’s authority”
• 86% (69/80) were incapacitated
  • Only 9% had explicit documentation
• Loss of capacity largely inferred
  • Patients intubated and sedated or with altered mental status

Issue 3: Lack of Clarity About Patient Preferences

• 30% (n=24) unclear if patient’s preferences honored
  • 22/24: no AD in record and no prior conversation with family
    • Patients’ families made best guess decisions
  • 2/24: DPOA went against AD
    • Patient 1: DPOA felt that AD went against patient’s wishes and prior AD
    • Patient 2: patient reportedly told OSH to make “full code”, DPOA disagreed
Issue 4: Patient Preferences Not Followed

- 67.5% (n=54) care consistent with preferences
- 2.5% (n=2) care not consistent with preferences
  - Patient 1: CPR started in ED → during resuscitation, team confirmed that patient was DNR → code stopped
    - No AD or P-DNR in record
  - Patient 2: PEA arrest at OSH → resuscitated including intubation → transferred to DHMC → “DPOA” withdrew care
    - AD specifying no life-sustaining treatment if permanently unconscious or near death scanned into DHMC chart after death

Student Recommendations

- Root cause analysis
- EMR changes
  - Utilize “Advance Care Notes” section
  - Identify decision maker in banner
- Improve documentation of capacity
  - Incorporate into templates
  - Smart Phrase for activating DPOA
Communication Planning

• Audiences: DHMC General Counsel, CMO, Ethics Committee, Clinical Policies Committee, Chief Medical Information Officer
• Message:
  – We are out of compliance with NH Law
  – Our practices are inconsistent with our values and reputation
  – We can change policies, procedures and our EMR to make it easy to do the right thing

Updated D-H ACP Policy (16389) and Procedures (16390, 16391)
AD documentation noted on EPIC banner and health maintenance module
Policy Changes/ Updates: From One on AD’s to Three Policies

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Surrogate Health Care Decision Making Policy: How to Identify a Health Care Agent under an Advance Directive or Other Surrogate for Patients Lacking Capacity; Understanding the Authority of an Agent or Other Surrogate Decision Maker</th>
<th>Policy ID: 16389</th>
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<td>Keywords</td>
<td>Surrogate, surrogate decision maker, advance directive, living will, guardian, durable power of attorney for health care, DPOAH, DPOA, DPOAHIC, next of kin, agent</td>
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Policy Changes/ Updates: From One on AD’s to Three Policies

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<th>Facilitating Advance Directives for Patients Procedure</th>
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### Demographics

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>52.5% M</td>
<td>62% M</td>
</tr>
<tr>
<td></td>
<td>48% F</td>
<td>38% F</td>
</tr>
<tr>
<td>Median Age</td>
<td>76.9</td>
<td>71.5</td>
</tr>
<tr>
<td>Mean Length of Stay</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Transferred from Outside Hospitals</td>
<td>40%</td>
<td>56%</td>
</tr>
<tr>
<td>AD in EMR at Time of Death</td>
<td>43%</td>
<td>45%</td>
</tr>
</tbody>
</table>

### Patient Preferences Honored

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<th>2017</th>
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<tr>
<td>Patient preferences clearly stated in EMR</td>
<td>56/80 (70%)</td>
<td>50/80 (63%)</td>
</tr>
<tr>
<td>Care consistent when preferences were stated</td>
<td>38/56 (67.5%)</td>
<td>45/50 (90%)</td>
</tr>
<tr>
<td>Decisions were made by legally documented decision makers</td>
<td>Not assessed</td>
<td>48/80 (68%)</td>
</tr>
</tbody>
</table>
Documentation of Loss of Capacity

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<tr>
<td>Total incapacitated</td>
<td>69/80 (86%)*</td>
<td>67/80 (84%)</td>
</tr>
<tr>
<td>% with explicit documentation of incapacity</td>
<td>6/69 (9%)</td>
<td>18/67 (27%) **</td>
</tr>
</tbody>
</table>

*Loss of capacity largely inferred from patient context

** 73% of documentation within a DNR order. Still NOT in compliance with NH law

Response to findings

Updated D-H ACP Policy (16389) and Procedures (16390, 16391)

AD documentation noted on EPIC banner and health maintenance module

Coming Soon:
- Advance Care Planning navigator in EPIC
- System wide education
- Alignment of “Serious Illness Conversation” (Dr. Amelia Cullinan) with Honoring Care Decisions Work
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Lessons Learned

• Death chart audits can shine a light on reality
• Leadership is needed to make sense of the realities, elevate awareness, and promote change
• Change takes time, communication planning, diverse input and acceptance
• Implementation planning involves policy changes, workflow/ EMR changes, and provider/ staff education
• We can learn from others on how to improve our own Death Chart Audits
## Clinical Audit

<table>
<thead>
<tr>
<th>Clinical Audit Indicator</th>
<th>Cases in Clinical Audit</th>
<th>National Result n=9302 % of Cases</th>
</tr>
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<tbody>
<tr>
<td>Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days? % YES</td>
<td></td>
<td>83%</td>
</tr>
<tr>
<td>Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient? % YES</td>
<td></td>
<td>79%</td>
</tr>
<tr>
<td>Is there documented evidence that the patient was given an opportunity to have concerns listened to? % YES or NO BUT</td>
<td></td>
<td>84%</td>
</tr>
<tr>
<td>Is there documented evidence that the needs of the person(s) important to the patient were asked about? % YES or NO BUT</td>
<td></td>
<td>56%</td>
</tr>
<tr>
<td>Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care? % YES</td>
<td></td>
<td>66%</td>
</tr>
</tbody>
</table>
By now, you should appreciate these learning Outcome objectives:

1. Performing a death chart audit can help identify and improve person-centered advance care planning outcomes.
2. Understanding the results and impact of a death chart audit tool in a large health system may lead to person-centered policy, procedure and educational opportunities for providers and staff.

What else would you like to know?