EDITORIALS

Making Progress With Code Status Documentation

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In the hospital, cardiopulmonary resuscitation (CPR) is the default treatment for a patient who suffers a cardiac arrest. Clinician assessment of patient preferences regarding resuscitation, with appropriate documentation in the medical record, is therefore essential for patients who do not wish to be resuscitated.[1] In addition, given frequent patient handoffs between physicians, consistent documentation of patient preferences is critical.[2] Unfortunately, multiple deficiencies in the quality of code status documentation have been identified in prior work.[3,4] In this issue of the *Journal of Hospital Medicine*, Weinerman and colleagues[5] build on this literature by not only evaluating the completeness of code status documentation in multiple documentation sites, but also its consistency.

In this Canadian multihospital study, the authors found that only 38 of the 187 patients (20%) admitted to 1 of 4 medicine services had complete and consistent documentation of code status. Even more worrisome is that two-thirds of the patients had inconsistent code status documentation. Although most of these inconsistencies involved missing information in 1 of the 5 sites of documentation (progress note, physician order, electronic resident sign-out lists, nursing-care plan, and do-not-resuscitate [DNR] face sheet), 31% were deemed clinically significant (eg, DNR in 1 source and full code in another). Such inconsistent documentation represents a serious threat to patient safety, and highlights the need for interventions aimed at improving the quality and reliability of code status documentation.

The authors identified 71 cases where code status documentation in progress notes was missing or inconsistent with documentation in other sites. Sixty of these notes lacked mention of a preference for full code status, 10 lacked documentation of DNR status, and 1 note incorrectly documented full code rather than DNR status. Interpretation of these findings requires consensus on whether the progress note is an appropriate location for code status documentation. With the evolution of the electronic medical record,

the role of the progress note has changed, and unfortunately, these notes have become a lengthy chronicle of a patient's hospital course that includes all clinical data, medical problems, and an array of bottom-of-the-list items such as code status. Information is easily added, but rarely removed, and what remains often goes unedited even for high-stakes issues such as code status. Given the potential for copying and pasting of progress notes day after day, it is critical that clinicians periodically review the code status documented in the patient's notes and update this information as those preferences change. One solution that may minimize the potential for inaccurate documentation in progress notes is for institutions to utilize a separate note for code status documentation that the clinician fills out following any code status discussion. Having this note clearly labeled (eg, Code Status Note) and in a universal place within the electronic record may provide a reliable and efficient way for both physicians and nurses to identify a patient's preferences, while minimizing the inclusion of repetitive information in daily notes. Furthermore, if entered into a discrete field within the electronic record, this information could then autopopulate other sites (eg, sign-out, nursing forms), thereby maintaining consistency. Use of note templates can provide a way to then help standardize the quality of information that is included in this type of code status note.

An alternate solution that may minimize the potential for inaccurate implementation of code status preferences is to focus on the fact that they are orders. As this study highlights, there is a need to improve both the completeness and consistency of code status documentation and, to this end, orders such as the Medical Orders for Life-Sustaining Treatment (MOLST) or Physician Orders for Life-Sustaining Treatment (POLST) may help.[6] Not only do these orders expand upon resuscitation preferences to include broader preferences for treatment in the context of serious illness, but they are also meant to serve as a standard way to document patient care preferences across healthcare settings. Although the MOLST and POLST primarily aim to translate patient preferences into medical orders to be followed outside of the hospital, their implementation into the electronic medical record may provide a more consistent way to document patient preferences in the hospital as well.

Although many studies have identified the need to improve the quality of code status discussions,[7–10] the work by Weinerman and colleagues reminds us that

attention to documentation is also critical. Ensuring that the electronic medical record contains documentation of the patient's resuscitation preferences and overall goals of care, and that this information can be found easily and reliably by physicians and nurses, should drive future quality improvement and research in this area.

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