

ALLOWING NATURAL DEATH IN THE EMERGENCY DEPARTMENT

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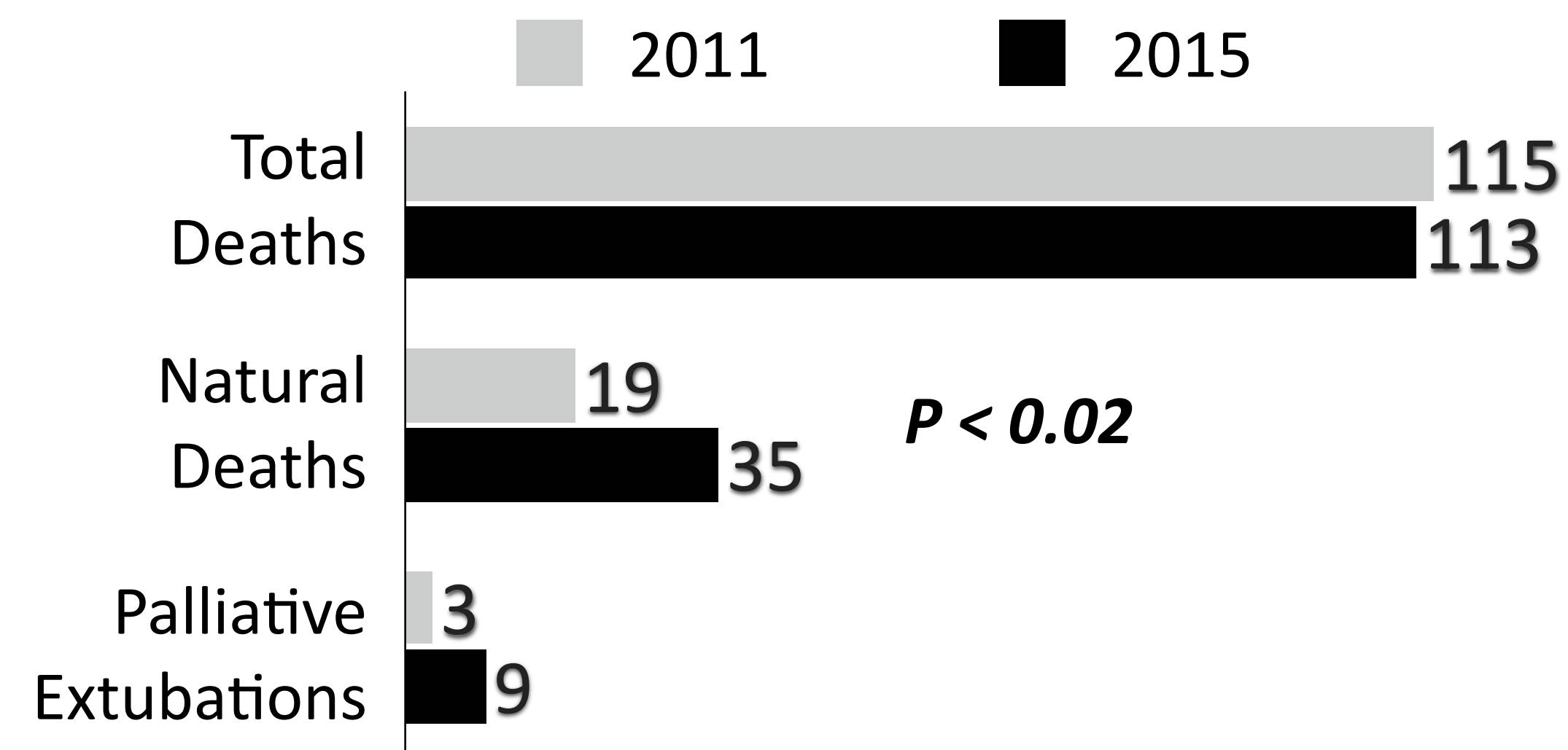
Background

- A 50% reduction in adult Emergency Department (ED) mortality rates from 1997 to 2011 was reported by Kanzaria (Health Affairs, 2016).
- Teno noted an increase in deaths occurring in hospice and fewer in-hospital deaths comparing 2000, 2005 and 2009 (JAMA, 2013).
- Despite these trends, the demands of caring for a dying patient, especially in the final hours, often motivates an ED visit.
- The Emergency Physician (EP) and support staff must then simultaneously manage the dying patient and support family in decisions regarding resuscitation and/or palliative care.
- We propose a new metric for this difficult situation: "Allowing Natural Death in the ED."
- In light of recent efforts in our ED to improve end-of-life (EOL) care, in addition to efforts to increase Advance Care Planning (ACP) documentation in the surrounding community, we sought to quantify an improvement in this metric in 2015 vs 2011.

Methods

- Retrospective review of electronic medical records of consecutive deaths in 2011 and 2015 in an academic urban Level 1 Trauma Center ED with an annual census of about 85,000.
- "Natural Death Allowed" was defined as death allowed after a decision was made, in a patient with spontaneous circulation, to allow cardiac or respiratory arrest without intervention.
- Fisher's exact test was used to determine statistical significance.

Results



- *Census & acuity were similar for both years.*
- *EOL discussions were the most common motivating factors towards Allowing Natural Death.*

Discussion

A significant increase in ED Natural Deaths Allowed and Palliative Extubations was noted in 2015 vs 2011.

Possible reasons for this trend:

- Provider, patient and family education.
- Increased EP skill with EOL discussions and in caring for dying patients.
- ED EOL Quality Improvement (QI) Project: improving EP ICU stewardship and ACP documentation for unstable EOL patients.
- Institutional QI Projects: Improving ACP documentation for EOL patients and ensuring care is consistent with patient's goals and values.

Limitations:

- Unable to perform exhaustive review of QI data.
- True frequency of ACP documentation and compliance with patient goals and values is unknown.

Future Projects:

- Medical Center's Quality Council formed the ED EOL Task Force including EP's, ED Nurses, Supportive Care Medicine, Performance Improvement, Social Work, Case Management, Pharmacy, and Chaplaincy to improve the care of ED EOL patients.

Allowing Natural Death in the ED can be the most compassionate option for dying patients.