5 The Impact of a Cardiopulmonary Resuscitation Video on End-of-life Decisions of Emergency Department Patients

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Objective: We conducted a survey of patients to determine if end-of-life decisions, specifically a do-not-resuscitate (DNR) order, would be influenced by a video depicting cardiopulmonary resuscitation (CPR) in an emergency department (ED) setting.

Design and Methods: In this cross-sectional study, participants were selected from within the ED at the University of Toledo Medical Center. Participants completed a survey in which they provided the following information: age; race; sex; knowledge of DNR, and if so, who informed them what DNR is); if they had a DNR; and if they considered themselves to be persons of faith. Participants who were familiar with a DNR were then asked to watch a video depicting CPR performed on a patient. (The outcome of the CPR efforts was left unknown to participants.) Participants were then asked how accurately the video depicted CPR, and if after watching the video they had changed their mind with regard to their own DNR status.

Results: There were 179 participants in the study ranging from 18 to 85+ years of age. Of these, 51% were female, 78% were White, 18% were Black, and the remaining were Hispanic, Asian or Native American. We learned that 86% considered themselves persons of faith; 94% had heard of DNR; 30% had an established DNR status; and 85% of participants did not change their minds about their own DNR status, after watching the video.

Conclusion: Our survey results demonstrated that the majority of patients would not change their DNR status after watching a video portraying CPR and other resuscitative efforts. Physicians can perhaps have more confidence that patients are making informed decisions regarding their code status, without necessarily needing in-depth details. However, a factor that limited the study results was the number of patients (30%) who had an established DNR,. Each participant, whether or not they had a DNR status established, was asked if they had changed their mind about their own DNR status subsequent to watching the video; however, the majority of them did not have a DNR status prior to watching the video. Therefore, the results stating that 85% of participants did not change their mind about their DNR status may not accurately represent the percentage of patients who would not change their mind, given that the majority were perhaps neutral to the question.

6 Assessment of Post-graduate Year Training and Unplanned Floor to Intensive Care Unit Transfers

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Background: Academic emergency departments (ED) use residents of different post-graduate year (PGY) training levels to provide clinical care for patients under the supervision of attending physicians. Admitted patients who have an unplanned transfer from the floor to the intensive care unit (ICU) within 24 hours have been shown to have higher mortality and are a potential focus for quality improvement. It is unclear if the level of training of the emergency medicine (EM) resident correlates with unplanned transfers.

Methods: We performed a retrospective chart review with a primary outcome measure of unplanned floor to ICU transfers within 24 hours after ED admission. The variable of primary interest was PGY level. The study was done at an urban, academic tertiary care referral center with an affiliated three-year EM residency. All patients presenting to the ED between 07/01/2012 to 06/30/2015 were eligible. We used logistic regression to test for significance and to control for confounders such as emergency severity index (ESI), age, gender, unstable vital signs at triage, changes from ED observation to full hospital admission, ED length of stay (LOS), and time to doctor. Odds ratios (OR) with 95% confidence interval (CI) were used as the primary effect estimate.

Results: We reviewed the records of 60,609 admitted patients and found 1,769 (2.9%) were unplanned transfers from floor to ICU within 24 hours. The OR for each resident PGY level and attending physicians are as follows: PGY1 0.47 (CI 0.39-0.49); PGY2 0.43 (CI 0.38-0.48); PGY3 0.42 (CI 0.37-0.47); and attendings 0.21 (CI 0.20-0.22). There is an inverse relationship between the ORs of unplanned floor to ICU transfers and EM PGY level. This is not statistically significant as all p-values are greater than 0.05. Unstable vital signs at triage, age, ESI, ED LOS, ED observation status that required admission, time of arrival to time seen by physician, and gender were significant predictors of unplanned floor to ICU in 24 hours with a p-value of < 0.05.

Conclusion: This data shows that there was no significant difference between the PGY training level of the EM resident and unplanned floor to ICU transfer within the first 24 hours. Identification of variables significantly related with unplanned floor to ICU transfer within 24 hours may be valuable to prevent this adverse event.