SURROGATE:

MAKING CAPACITY, IDENTIFY A
IF THE PATIENT LACKS DECISION-
DETERMINATION OF THE PATIENT'S
TIMING OF INITIAL DISCUSSION:
with one or more of the following characteristics:
Trauma and emergency general surgery patients
the patient's goals, preferences, and values.
goals of care
for an initial discussion to address overarching goals of care and code status, in the context of the patient's goals, preferences, and values.

TARGETED PATIENT POPULATION:
Trauma and emergency general surgery patients
with one or more of the following characteristics:
• Potentially life-threatening or disabling acute condition (injury or illness)
• Significant comorbid burden
• Frailty

TIMING OF INITIAL DISCUSSION:
• As soon as possible
• Within the first 24 hours after admission, and no later than 72 hours after admission
• If operative intervention is being considered, ideally prior to the operation

DETERMINATION OF THE PATIENT’S DECISION-MAKING CAPACITY:
• Decision-making capacity means that the patient must be able to understand, reason through, and communicate choices pertaining to their medical condition and treatment options.
• Any physician can make this determination.
• When in doubt, consult psychiatry.

IF THE PATIENT LACKS DECISION-MAKING CAPACITY, IDENTIFY A SURROGATE:
• Legal documentation of surrogate and preferences (advance directive, living will, durable power of attorney for health care, POS/L/MOLST)
• If no legal documentation is available, identify an informal surrogate (order of priority may vary by state statute): spouse; adult child; parent; adult sibling, etc.
• If no family, a person familiar with the patient’s goals, preferences, and values.
• Unbefriended patients (no identifiable surrogate): seek a court-appointed surrogate; until this is accomplished, the best interest standard applies.

THE CONTENT OF THE INITIAL DISCUSSION:
OVERARCHING GOALS OF CARE
• Explain diagnosis, prognosis, and treatment options.
• Listen in order to understand and establish the patient’s goals, preferences, and values.
• Tailor the treatment options to those that most closely align with the patient’s goals, preferences, and values.
• Establish preferences around other more general medical therapies:
  › “Artificial” hydration and nutrition
  › Renal replacement therapy
  › Tracheostomy in the management of chronic respiratory failure or inability to protect airway
  › Feeding access, including “temporary” nasoenteric tubes or “permanent” surgical feeding tubes in the management of dysphagia or other inability to self-sustain nutrition

CODE STATUS
Interventions to manage cardiopulmonary arrest and acute clinical deterioration exclusive of cardiopulmonary arrest should be carefully discussed in a cohesive manner in the overall context of the patient’s goals, preferences and values.

• Patient’s wishes for CPR in the context of cardiopulmonary arrest:
  › YES includes intubation and mechanical ventilation; chest compressions; and defibrillation.
  › NO does not provide any of the above interventions. The patient will not be resuscitated.
• Patient’s wishes for intervention in the context of acute clinical deterioration exclusive of cardiopulmonary arrest:
  › PROVIDE / DO NOT PROVIDE intubation and mechanical ventilation
  › PROVIDE / DO NOT PROVIDE noninvasive mechanical ventilation
  › PROVIDE / DO NOT PROVIDE electrical cardioversion
  › PROVIDE / DO NOT PROVIDE vasopressors / inotropes
  › DO / DO NOT transfer to a higher level of care

Scan For: PALLIATIVE CARE BEST PRACTICES GUIDELINES