Instructions: Choose one of the 2 case studies below to read and answer the corresponding reflection questions for that scenario. Submit to my dropbox and be prepared to discuss your responses in class.

Case 1 – Is it Okay to Change Your Mind?

A 90-year-old female, Mrs. Ruth, is admitted to hospital from home after sustaining a hip fracture. She has a history of chronic obstructive pulmonary disease on home oxygen and moderate to severe aortic stenosis. She undergoes urgent hemiarthroplasty (hip surgery) with an uneventful operative course.

Unfortunately, on postoperative day 4, the patient develops delirium with respiratory failure secondary to hospital acquired pneumonia and pulmonary edema. Her goals of care were not assessed pre-operatively. She is admitted to the ICU for non-invasive positive pressure ventilation for 48 hours, and then deteriorates and is intubated. After 48 hours of ventilation, it was determined that due to the severity of her underlying cardio-pulmonary status (COPD and aortic stenosis), ventilator weaning would be difficult and further ventilation would be futile.

The patient's daughter is insistent on continuing all forms of life support, including mechanical ventilation and even extracorporeal membranous oxygenation (ECMO) if indicated. However, Mrs. Ruth's delirium clears within the next 24 hours of intubation, and she is now competent, although still mechanically ventilated. She communicated to the ICU team that she preferred 1-way extubation (removal of the ventilator) and comfort care. This was communicated in writing to the ICU team and was consistent over time with other care providers. The patient went as far to demand the extubation over the next hour, which was felt to be reasonable by the ICU team.

The patient's daughter was informed of this decision and stated that she could not come to the hospital for 2 hours, and in the meantime, that the patient must remain intubated. At this point, the ICU team concurred with the patient's wishes, and extubated her before her daughter was able to come to the hospital.

The daughter was angry at the team's decision and requested that the patient be re-intubated if she deteriorated. When the daughter arrived at the hospital, the patient and daughter were able to converse, and the patient then agreed to re-intubation if she deteriorated.

1. Who do you think should make decisions in this situation? Should the ICU team have extubated the patient?

   I think Mrs. Ruth (pt) should make the decision in this situation because her delirium has cleared, and she communicated her wishes multiple times and they were consistent. The case also does not state that the daughter has decision making abilities (IE: power of attorney). So unless her mom is incapable of making decisions and the daughter obtains a POA or the mothers becomes incapacitated and unable

to express her wishes about things other than reintubation (because she has already consented to this), then the ICU team should follow Mrs. Ruth's request

2. Do you think the patient should be allowed to change her mind?

   Absolutely! If she were to repeat this scenario and deteriorated and was reintubated and then asked to be extubated, as long as she is of sound mind and communicates her wishes and remains consistent through multiple interaction, that is her right.

3. Does the change in the patient's decision mean that she lacked the capacity to make the decision in the first place, or that she was not well informed?

   I believe it was that she was not well informed. Had anyone in the perioperative setting discussed this before surgery with Mrs. Ruth, she could have made her wishes clear, been walked through her option, provided education about possible scenarios and outcomes, and could have had the opportunity to speak with her family. Since that opportunity was missed, this created confusion about true wishes.

4. The patient's goals of care were not assessed preoperatively. When do you think would have been the ideal time to have that conversation with the patient?

   This could have been assessed when the provider first realized she had a fx and needed sx. When the provider was informing her and getting consent, that could have been an opportunity to explain risk and potential complications. Nursing could have done it while completing pre op check list and seeing if she had an advanced directive in case something went wrong. I understand that her hip sx was urgent, but this is a conversation that is easy enough to document in the chart and then could have been saved and/or changed throughout her hospital stay,