Unsafe Discharges: Ethics, Risk Reduction, and Obligations, Part 1

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PCV13 use in a specific individual aged ≥65 years, the considerations may include the individual’s risk for exposure to PCV13 serotypes and risk for pneu

mococcal disease as a result of underlying medical conditions.

If a decision to administer PCV13 is made, it should be administered before PPSV23. PCV13 and PPSV23 should not be coadministered. The recom

mended intervals between pneumococcal vaccines remain unchanged for adults without an immunocompromising condition, CSF leak, or cochlear implant: ≥1 year between pneumococcal vaccines, regardless of the order in which they were received.

ACIP continues to recommend PCV13 in series with PPSV23 for adults aged ≥19 years (including those aged ≥65 years) with immunocompromising conditions, CSF leaks, or cochlear implants.

PPSV23 for adults aged ≥65 years. ACIP continues to recommend that all adults aged ≥65 years receive one dose of PPSV23. A single dose of PPSV23 is recommended for routine use among all adults aged ≥65 years. PPSV23 contains 12 serotypes in common with PCV13 plus an additional 11 serotypes that account for 32%–37% of invasive pneu

mococcal disease among adults aged ≥65 years. Adults who received one or more doses of PPSV23 before age 65 should receive an additional dose of PPSV23 at age ≥65 years, at least five years after the previous PPSV23 dose.

Summary

The CDC estimates there were approxi


For the 2020–2021 flu season, the CDC has recommended that all Americans receive a flu vaccine, and adults aged ≥65 receive an appropri


ly/2LF5PSy). The key concepts address:

• Reducing facility risk
• Isolating symptomatic patients as soon as possible
• Protecting health care personnel
Specific, regularly updated guidance for long-term care, assisted living, and other health care facilities is available on the CDC site.

The 2020–2021 flu season will no doubt be challenging for health care professionals who must distinguish between influenza, pneumonia, and COVID-19 in patients who present with respira

tory illness. Infectious disease protocols should be routine in all facilities, and they must include but are not limited to hand washing, wearing of personal protective equipment by all health care workers, using rapid diagnostic tools to determine pathogen(s) promptly, and administering medication protocols where suitable.

Vaccinating patients and staff with the appropriate vaccines minimizes the spread of infectious disease. Timely identification of pathogens, isolation of infected individuals, and swift initiation of the proper treatment(s) are key to limiting disease transmission and maintaining good health for all patients and health care workers. The lessons we have learned from the disastrous impact of COVID-19 on long-term care, assisted living, and senior communities in the United States will hopefully prepare us for the 2020–2021 flu season and what lies ahead.

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acist since 1990 and a Board Certified Geriatric Pharmacist since 1998. She is currently a clinical advisor for CVS/ Caremark, coordinating with account teams and health plans on the details of their pharmacy benefit offerings, formulary implementation, medication utilization management, and MTM as well as providing clinical information and geriatric expertise. Any opinions in this article are that of the author and not of CVS/ Caremark.

Discharge against medical advice, sometimes called discharge prior to completion of treatment, can be facilitated using the AIMED approach: Assess, Investigate, Mitigate (harm), Explain, and Document.

James Wright, MD, PhD, CMD, chair of the ethics subcommittee of AMDA – The Society for Post-Acute and Long-Term Care Medicine, sometimes uses an alternative term: “Discharge Prior to Completion of Treatment.” When asked to facilitate such a discharge, he uses the AIMED approach (Acad Emerg Med 2014;21:1050–1057):

• Assess decision-making capacity and the degree of illness and risk involved, particularly if the patient is refusing treatment.
• Investigate why the patient wants to leave, what concerns can be addressed, and which allies could help convince the patient to stay. Common patient concerns surrounding discharge AMA include finances, loss of control, fear, stigma of being in a nursing or “old folks” home, uncontrolled symptoms, and loss of trust.
• Mitigate harm: Do your best to help the patient by offering maximal acceptable treatment to the patient, providing prescriptions, and arranging follow-up appointments. Offering substandard care is less risk than offering no care at all.
• Explain the risks and benefits of leaving AMA and offer (pending approval by administration) admission back to the facility should the patient choose to return.
• Document each of the above elements in the chart. Successful legal suits tend to have one thing in common: poor documentation. Include examination and assessment of the disease and discussion of treatment. Document the patient’s knowledge of the consequences of refusal and reasons for refusal, the efforts at...
The literature in recent years has distinguished competency, a legal determination, from capacity, a medical determination. The gold standard for decision-making capacity is a clinical examination by a physician who is trained to evaluate capacity and has performed many evaluations. Although psychiatrists are commonly consulted, all licensed physicians may conduct the evaluation. Interdisciplinary team members and standardized tools can take the burden off any one physician.

Assessing Decision-Making Capacity

An evaluation for medical decision-making capacity is commonly triggered when patients exercise autonomy to make decisions that appear unsafe, such as discharging AMA. The literature in recent years has distinguished competency, a legal determination, from capacity, a medical determination. The gold standard for decision-making capacity is a clinical examination by a physician who is trained to evaluate capacity and has performed many evaluations. Although psychiatrists are commonly consulted, all licensed physicians may conduct the evaluation. Interdisciplinary team members and standardized tools can take the burden off any one physician.

The criteria for determining decision-making capacity are the patient’s ability to understand the decision to be made, to appreciate the need for making a decision, to reason among the factors weighing into it, and to express a choice. Singh Palat, MD, CMD, with CMDA – The Colorado Society for Post-Acute and Long-Term Care Medicine, recommends using a standardized tool, such as the Aid to Capacity Evaluation (ACE), to conduct the capacity assessment. The ACE may be implemented in under 30 minutes and is available online, free for noncommercial use (http://www.jcb.utoronto.ca/tools/documents/ace.pdf).

Cognitive tests such as the Mini Mental Status Examination (MMSE) are designed to screen for dementia, not capacity. Yet cognitive testing is often used a surrogate for decision-making capacity. Studies have shown that very low MMSE scores (<16 of 30) correlate with lack of capacity and high scores (>24) correlate with intact capacity (JAMA 2011;306:420–427). Patients scoring in the moderate range (16 to 24) require more comprehensive assessment. In fact, a comprehensive assessment should be considered for all patients; in one cohort with very low MMSE scores, one in three patients still demonstrated intact capacity (J Psychiatry Law 2012;40:243–263).

Cognitive function is just one dimension of decision-making. Other dimensions to assess include the social situation, religion, culture, medicolegal issues, environment, and risk of abuse. Also, addressing hearing and vision impairments and attempting to resolve the presence of delirium, depression, and/or pain enhance the assessment.

Capacity is both decision specific and time specific. Decision specific acknowledges that each decision carries certain risks and benefits, which determine the threshold needed for capacity. High-risk decisions require patients to demonstrate a higher level of capacity. Low-risk decisions require a lower threshold. Time specific refers to the fact that capacity may be lost or regained depending on the circumstances. A patient may lack capacity when experiencing delirium, for instance, but regain it when delirium clears.

Both the examination findings and the conclusion must be documented. Document responses to the interview using a standardized tool such as the ACE, cognitive test scores, and relevant multidimensional factors. The conclusion about whether the patient’s capacity is intact should reference the specific decision being considered as well as when the evaluation should be repeated.

Part 2 of this article will be published in the next issue of Caring for the Ages (21/7).

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