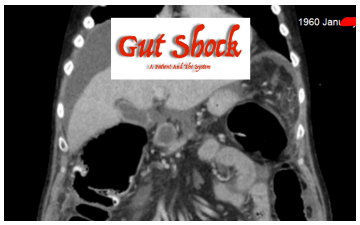


Unauthorized "No Code"

On Friday, September 11, 2015 The Patient's Wife met with Nephrologist "Dr. R. K." to discuss renal failure options for her husband The Patient. "Dr. R. K." said "your husband looks like a well man and he is young....so I think we should proceed with dialysis. Let's see how he does over the weekend and discuss it on Monday morning. As long as he is cognitive, we will do it....but if he becomes encephalopathic I would not advise it"

Progress Notes

L 131 | 102 | H 57 / 115
**4.9 | L 19 | H 5.2 **

Hg 8.9

Impression: AKI. multifactorial. Would continue Albumin (reordered 25 g tid), midodrine octreotide. On Cipro for SBP (cx negative). Would avoid large volume paracenteses as this can trigger AKI and HRS. Okay to do diagnostic paracentesis if needed.
I spoke with wife at length about renal disease. I suspect part of his AKI very well may be HRS but there are numerous other contributing factors (diuretics,paracentesis,SBP). U.O. is up and rate of creatinine rise is slower. I would like to watch over weekend with the hope that creatine starts to improve. If not we may need to discuss the role of dialysis (we had discussed this in the past and again today). If he needed dialysis, the combination of liver and renal failure portends a very grim prognosis but given his mental state we could consider it if needed.

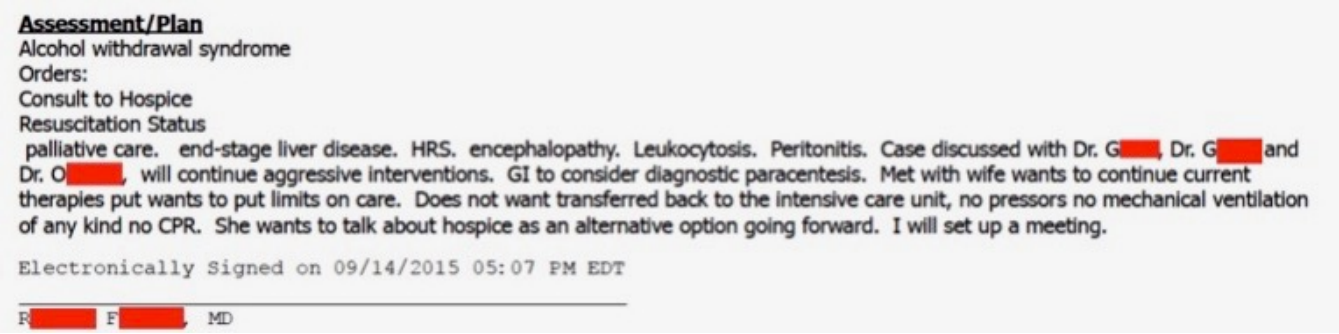
R[redacted] K[redacted] MD
[redacted]

Electronically Signed on 09/11/2015 12:28 PM EDT

R[redacted] K[redacted] MD

On Saturday, September 12, 2015, a nurse informed The Patient's Wife that The Patient's lactulose was stopped and a milder version was given. The Patient's Wife discussed with The Patient's Father in Florida that she feared if it was milder that he may have ammonia build up which could trigger encephalopathy and therefore he may be denied the life extending dialysis treatment. On Sunday, September 13, 2015, The Patient exhibited a reduction in cognition and increased sleepiness and The Patient's Wife did not sleep all night due to anxiety about the meeting with "Dr. R. K." on Monday regarding his decision about starting dialysis.

On Monday, September 14, 2015, “Dr. R. K.” never met with The Patient's Wife and Palliative Care “Dr. R. F.” came in to The Patient’s room to tell The Patient’s Wife that dialysis was not “not an option”. He said that it has been 60 days since The Patient arrived at the Catholic Hospital and they need a need a new plan of care. The Patient and his wife, despite this pressure, emphatically reiterated that they wanted to exhaust all options to continue to fight. However “Dr. R. F.”’s note regarding this encounter said just the opposite.

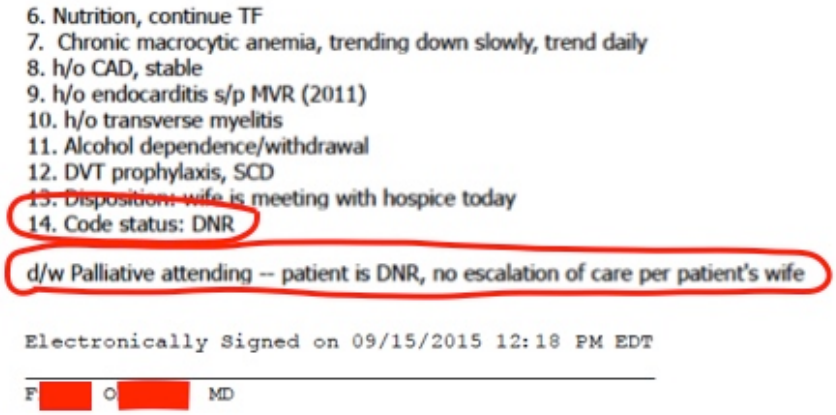


Assessment/Plan
Alcohol withdrawal syndrome
Orders:
Consult to Hospice
Resuscitation Status
palliative care. end-stage liver disease. HRS. encephalopathy. Leukocytosis. Peritonitis. Case discussed with Dr. G[redacted], Dr. G[redacted] and Dr. O[redacted], will continue aggressive interventions. GI to consider diagnostic paracentesis. Met with wife wants to continue current therapies put wants to put limits on care. Does not want transferred back to the intensive care unit, no pressors no mechanical ventilation of any kind no CPR. She wants to talk about hospice as an alternative option going forward. I will set up a meeting.

Electronically Signed on 09/14/2015 05:07 PM EDT

R[redacted] F[redacted], MD

In a Progress Note dated September 15, 2015, “Dr. F.O.”, Hospitalist, noted that Kevin Hunt’s Code had been changed.



6. Nutrition, continue TF
7. Chronic macrocytic anemia, trending down slowly, trend daily
8. h/o CAD, stable
9. h/o endocarditis s/p MVR (2011)
10. h/o transverse myelitis
11. Alcohol dependence/withdrawal
12. DVT prophylaxis, SCD
13. Disposition: wife is meeting with hospice today
14. Code status: DNR

d/w Palliative attending -- patient is DNR, no escalation of care per patient's wife

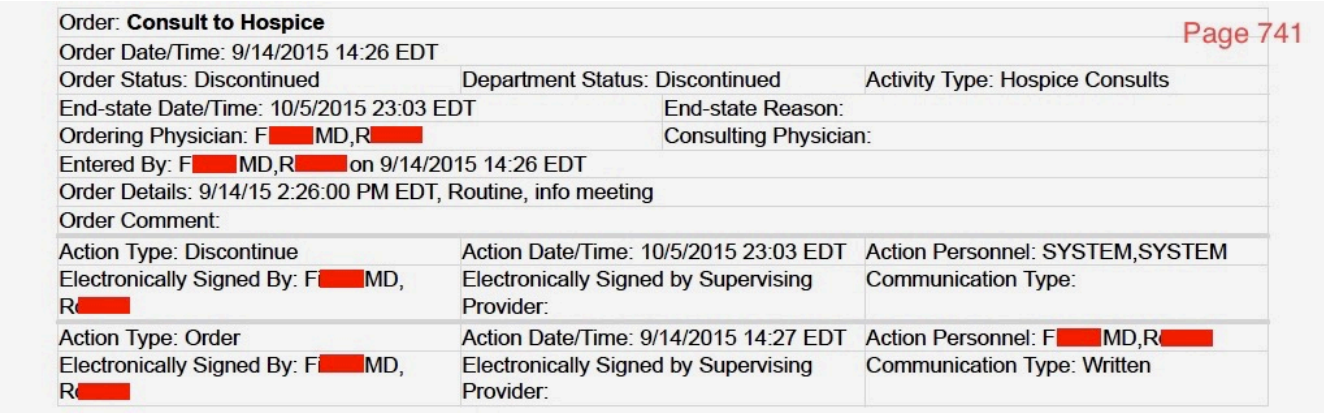
Electronically Signed on 09/15/2015 12:18 PM EDT

F[redacted] O[redacted] MD

Later, The Patient was moaning in hunger pain around lunch because the PEG feeding had stopped. The Patient's Wife talked to Gastroenterologist “Dr. T. G.” who was examining The Patient and asked why all feedings had stopped and he said they were waiting for a dietician to come and do a swallowing test to assess what diet he could handle. The Patient's Wife asked him why could they not at least do liquid feedings in the PEG tube and he said there is no reason why they could not and that he would. The Patient's Wife had to go home for the children’ arrival after school but phoned in around dinner time to check with the floor nurse that PEG food was given. The nurse verified that the feeding was still on

hold as they were still waiting for a dietician. The Patient's Wife became very agitated and emphatically asked why the PEG feeding stopped. The Patient's Wife asked her to call the hospitalist on duty and have them call her immediately on her cell phone to explain why they were starving her husband. Her cell phone rang 5 minutes later. It was not a doctor, but a nurse telling The Patient's Wife that she had hooked up The Patient's food.

On Tuesday, September 15, 2015, "Dr. R. F." came into The Patient's room to tell The Patient's Wife that he was setting up a meeting with a hospice worker to educate her on what services they provide. The record reflects that he had written the order on September 14, the previous day for a "Routine, info meeting".



Order: **Consult to Hospice**		Page 741
Order Date/Time: 9/14/2015 14:26 EDT		
Order Status: Discontinued	Department Status: Discontinued	Activity Type: Hospice Consults
End-state Date/Time: 10/5/2015 23:03 EDT	End-state Reason:	
Ordering Physician: F[redacted]MD,R[redacted]	Consulting Physician:	
Entered By: F[redacted]MD,R[redacted]on 9/14/2015 14:26 EDT		
Order Details: 9/14/15 2:26:00 PM EDT, Routine, info meeting		
Order Comment:		
Action Type: Discontinue	Action Date/Time: 10/5/2015 23:03 EDT	Action Personnel: SYSTEM,SYSTEM
Electronically Signed By: F[redacted]MD, R[redacted]	Electronically Signed by Supervising Provider:	Communication Type:
Action Type: Order	Action Date/Time: 9/14/2015 14:27 EDT	Action Personnel: F[redacted]MD,R[redacted]
Electronically Signed By: F[redacted]MD, R[redacted]	Electronically Signed by Supervising Provider:	Communication Type: Written

Reluctantly, The Patient's Wife met that afternoon with a Hospice and Home Care organization, located 50 minutes away from their home, with her sister-n-law, "Sister E.T.". At the onset of the meeting, The Patient's Wife asked if The Patient could get dialysis and lactulose in hospice and the representative said no and The Patient's Wife said, "then the meeting is over". The meeting lasted less than 2 minutes.

On Wednesday September 16, 2015, The Patient's Wife received a call while at the Hospital from a friend, Rxxxx Pxxxxxxx, to whom she had conveyed her concerns about the discontinuation in The Patient's feeding and and some of his medications (lactulose). Rxxxx said that she had talked to an ICU nurse, "K.B. RN", at a nearby Hospital and relayed that lactulose was stopped, feeding was stopped and "Dr. R. F." had said that dialysis was not an option. "K.B. RN" told The Patient's Wife to ask what his code was because it sounded like they are withdrawing care.

The Patient's Wife and her sister-in-law, "Sister E.T." immediately went to the Nurses' Station and asked to see a doctor, urgently. Almost immediately, CC Hospitalist "Dr O.F." arrived and The Patient's Wife and "Sister E.T." asked what

his code was and she said “No Code, there is a DNR”. The Patient's Wife became hysterical and demanded to know who authorized that and that she want it changed. CC Hospitalist, “Dr. O. F.” changed the code in the computer in front of The Patient's Wife and “Sister E.T.” who expressed their displeasure regarding “Dr. R. F.”’s intervention. The Patient's Wife then said she wanted to get her husband transferred to another facility where they would promote his life rather than promote his death. While “Dr. R. F”’s original order is not in any of the records the family have received from the Catholic Hospital, “Dr. O.F.”’s Order to cancel the DNR is in the records.

Patient Care

Order: **Resuscitation Status**		
Order Date/Time: 9/14/2015 14:26 EDT		
Order Status: Discontinued	Department Status: Discontinued	Activity Type: Continuous Asmt/Tx/Monitoring
End-state Date/Time: 9/16/2015 15:47 EDT	End-state Reason:	
Ordering Physician: F[redacted] MD,O[redacted]	Consulting Physician:	
Entered By: F[redacted] MD,R[redacted] on 9/14/2015 14:26 EDT		
Order Details: 9/14/15 2:26:00 PM EDT, DNR w/ Interventions, Refer to Code Status Documentation, Spouse, no escalation of care, no mechanical vent, no pressors		
Order Comment:		
Action Type: Discontinue	Action Date/Time: 9/16/2015 15:47 EDT	Action Personnel: F[redacted] MD, O[redacted]
Electronically Signed By: F[redacted] MD, O[redacted]	Electronically Signed by Supervising Provider:	Communication Type: Written
Action Type: Order	Action Date/Time: 9/14/2015 14:27 EDT	Action Personnel: F[redacted] MD,R[redacted]
Electronically Signed By: F[redacted] MD, R[redacted]	Electronically Signed by Supervising Provider:	Communication Type: Written

The Patient's Wife told “Dr. O. F.” she was not fond of “Dr. R. F.” and that she felt he was a Dr. Kevorkian. She asked “Dr. O. F.” if “Dr. R. F.” got commissions on hospice referrals and she said he does not, but that he wishes he did.

Plan
55 yo a PMH mvr, alcoholism, admitted in alcohol withdrawal, diagnosed in this admission with end stage liver disease> has since been inpatient with undulating alteration in mental status likely multifactorial, SBP X2 still on ciprofloxacin, now in hepatorenal syndrome
Have had an extensive discussion with his wife and sister today. They are concerned we are trying to withdraw care because he's been ill for so long.
I have clarified that we are here to support her and give Mr [redacted] the therapies he needs as far as its in keeping with his goals of care
She has requested that we make him full code.
She clearly states - I know he is dying and he knows =, but we want to get as much time as possible for him.
She is extremely interested in HD, I have explained that there are 2 schools of thought on HD in HRS, She understands that it will improve his quality of life.
Paracentesis today for comfort and to confirm resolution of SBP
Resume lactulose to goal of 2-3 BMs /day
I suspect his encephalopathy is still multifactorial but likely being heavily contributed to by his rising BUN
Low K diet. Nutrition to see. Hes currently get both oral and tube feeds, TO go for swallow study in am.
Continue other meds

His wife was significantly agitated today. She wanted to transfer him to another hospital because she is worried we would withdraw care without notifying her.
I have adviced taking a short break from further goals of care conversations.
We will await definitive recs from renal and this would ultimately dictate his short term trajectory.

Electronically Signed on 09/16/2015 07:30 PM EDT

O[redacted] F[redacted] MD

On Thursday September 17, 2015, The Patient's Wife then contacted a Big City Hospital in another state after losing confidence that the Catholic Hospital wanted to care for The Patient. The Big City Hospital's Transfer unit said the doctor from the Catholic Hospital needed to contact the Hepatology Doctor at Big City Hospital to brief him on on The Patient's care.

That morning, in a meeting in The Patient's room, The Patient's Wife told Hospitalist, "Dr. F. O." that she had lost faith in The Catholic Hospital's willingness to care for her husband since she learned he had a DNR instituted without family or patient consent. The Patient's Wife asked Hospitalist, "Dr. F. O." who authorized the DNR and he said he checked and it was "ordered by "Dr. R. F." per a conversation with The Patient's Wife. The Patient's Wife was outraged!

"Dr. F. O." noted that day that The Patient's Code status had been switched back to FULL CODE.

6. Nutrition, continue TF
7. Chronic macrocytic anemia, trending down slowly, trend daily
8. h/o CAD, stable
9. h/o endocarditis s/p MVR (2011)
10. h/o transverse myelitis
11. Alcohol dependence/withdrawal
12. DVT prophylaxis, SCD
13. Disposition: for vasopressin therapy
14. Code status: switched back TO FULL CODE

d/w nursing
d/w Dr. [redacted]

Electronically Signed on 09/17/2015 12:04 PM EDT

F[redacted] O[redacted] MD

The Patient was not in pain and still having qualitative visits with family and friends, especially his children...until the weekend's medical interventions had

stopped and toxins built up. That afternoon, Hospitalist, “Dr. F. O.” called The Patient's Wife on her cell phone and said he had a private consult with Big City Hospital and asked her to meet him in the lobby to discuss it. A family friend, Txx Exxxxx was leaving after a visit with The Patient and so joined the meeting. During the meeting, Hospitalist, “Dr. F. O.” stated that the typical prognosis for a patient with ESLD is 10 weeks and that The Patient was 2 weeks into it. The Patient's Wife and family friend, Txx Exxxxx said they understood his prognosis but wanted to spend every day possible with The Patient as long as he was willing and comfortable and they wanted to take the risk of dialysis.

The Patient's Wife then informed him that “Dr. R. F.” told both The Patient's Wife and “Sister E.T.” that dialysis could not be performed on The Patient and that because of this she was seeking a 2nd opinion. Hospitalist, “Dr. F. O.” said that dialysis was still an available option and that “Dr. R. F.” must have “misspoken”.

Txx Exxxxx witnessed the very extensive discussion regarding the lack of consent for the DNR.

Hospitalist, “Dr. F. O.” said typically patients are only transferred if there is a service that cannot be performed at their current location.

On Friday September 18, 2015, The Patient's Wife was informed, by phone, that dialysis was to start that day so she rushed to the hospital. She stayed until midnight, but dialysis was not done that day. Dialysis commenced on Saturday, September 19, 2015.

The Patient’s Wife stayed with The Patient for his 1st treatment and there were no problems with his blood pressure. The Patient was able to tolerate the dialysis.

On Monday, September 21, 2015, the Patient’s Other Sister (he has three) “Sister TA” went to the hospital early in the morning and was just outside his ICU room, when the Team of Doctors overseeing the floor were having their morning meetings outside each patient’s room. When they got to The Patient’s room, she overheard them discussing The Patient’s condition and the Dr doing the briefing, “Dr R. C.” stated “Then his wife changed his mind”. "Sister TA" happened to run into that “Dr. R. C.” in the late afternoon in the parking garage and told him she was very upset to hear that narrative regarding The Patient’s DNR because it was false. She told him emphatically that The Patient and his Wife NEVER changed their mind. The Family and The Patient only wanted to fight and to stay alive as long as possible.

On Tuesday, September 22, 2015, The Patient’s Wife called a meeting with the Case Manager “E.C. RN” request a copy of the DNR (No Code) order and to express The Family’s distress about a DNR (No Code) being put in place without

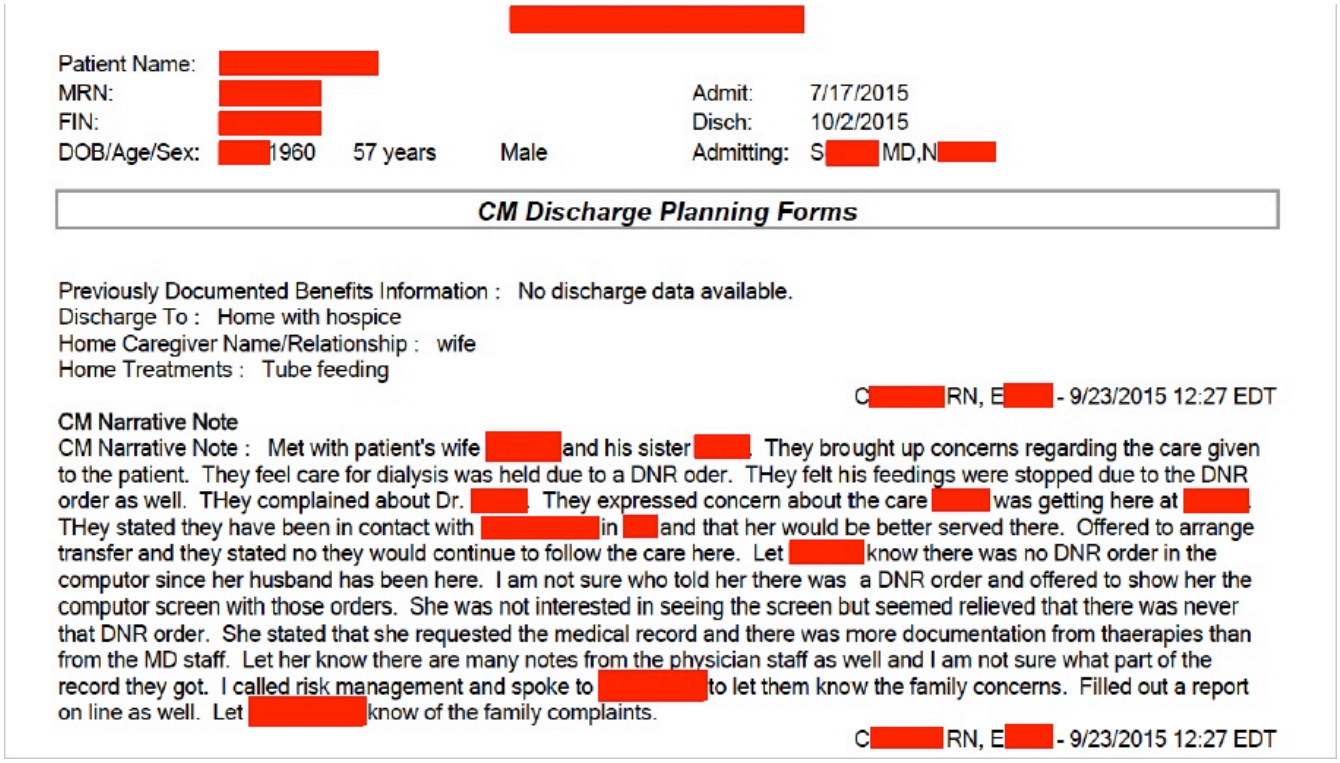
out consent of The Patient or any Family member. She said she would take the matter to the COO.

Soon after the meeting, she approached The Patient's Wife, who was alone while she waited for The Patient's bedding to be changed.
Case Manager "E.C. RN" told The Patient's Wife that she had checked the system and that there was NEVER a DNR (No Code) on The Patient and that The Patient's Wife mistook the term "No Code" for really "No directive at all".

Case Manager "E.C. RN" also said that there were lots of notes from "Dr. R. F." that concurred with and conveyed the family wishes to keep fighting. She said that "Dr. R. F." logged them in a separate notation column that would not have been included in the print out of the basic notes which explains why there is no information about the DNR (No Code) from "Dr. R. F."

Following that encounter, The Patient's Wife ordered the full medical records to include all notations in an effort to read all notations from "Dr. R. F." Having received only about 60 pages, most of which were Physical Therapy notes, The Patient's Wife found only one note dated August 31, and there was no mention of the Patient's Code in that note.

The Patient's Wife then requested a meeting with the Case Manager "E.C. RN" which occurred on Wednesday September 23 2015. They were shocked that the Case Manager told them that there was never a DNR (No Code) in the system. It was at this moment, they knew that there was something amiss in the Hospitals approach to Kevin's case. The Patient's Wife and "Sister ET" had witnessed "Dr O.F." change the code back to "Full Code" in the computer system. Why change the Code in the first place and then why lie about it? Why not just say it was a misunderstanding or error?



[redacted]

Patient Name: [redacted]
MRN: [redacted]
FIN: [redacted]
DOB/Age/Sex: [redacted]1960 57 years Male
Admit: 7/17/2015
Disch: 10/2/2015
Admitting: S[redacted] MD,N[redacted]

CM Discharge Planning Forms

Previously Documented Benefits Information : No discharge data available.
Discharge To : Home with hospice
Home Caregiver Name/Relationship : wife
Home Treatments : Tube feeding

C[redacted] RN, E[redacted] - 9/23/2015 12:27 EDT

CM Narrative Note
CM Narrative Note : Met with patient's wife [redacted] and his sister [redacted]. They brought up concerns regarding the care given to the patient. They feel care for dialysis was held due to a DNR oder. THey felt his feedings were stopped due to the DNR order as well. THey complained about Dr. [redacted]. They expressed concern about the care [redacted] was getting here at [redacted]. THey stated they have been in contact with [redacted] in [redacted] and that her would be better served there. Offered to arrange transfer and they stated no they would continue to follow the care here. Let [redacted] know there was no DNR order in the computor since her husband has been here. I am not sure who told her there was a DNR order and offered to show her the computor screen with those orders. She was not interested in seeing the screen but seemed relieved that there was never that DNR order. She stated that she requested the medical record and there was more documentation from thaerapies than from the MD staff. Let her know there are many notes from the physician staff as well and I am not sure what part of the record they got. I called risk management and spoke to [redacted] to let them know the family concerns. Filled out a report on line as well. Let [redacted] know of the family complaints.

C[redacted] RN, E[redacted] - 9/23/2015 12:27 EDT

Months later The Patient's Wife and "Sister TA" got their first copy of of what was purported to be The Patient's full Catholic Hospital Medical record (they have despite repeated requests never received the full record), they were shocked (and somewhat relieved) that to find that Case Manager "E.C. RN" had actually mostly accurately documented the meeting that took place that day. What she didn't know was that from the moment she emphatically stated that there was no "DNR (No Code)", The Patient's Wife and Sister knew there was something seriously wrong as they knew the Case Manager "E.C. RN" was lying. They changed the tone of the meeting to make her feel like they had been placated. However, the two began to plan to continue to try to move The Patient to another facility.

As the possibility of going to Big City Hospital had been "blocked", The Patient's Wife and "Sister TA" again met with Case Manager "E.C. RN" to see if Home Care could be an option as they were desperate to get him out of The Catholic Hospital.

C[redacted] RN, E[redacted] 9/28/2015 17:45 EDT

CM Narrative Note

Page 2148

CM Narrative Note : Met with wife and sister T[redacted]. They are requesting information about home care. Let her know I will get the name of agencies to contact for HHA. Can refer to any home care agency although they are interested in Hospice. They would like information regarding external options - home vs inpatient hospice facility. She would like brochures. She would like to know what her insurance will cover for this patient. Will contact the insurance company tomorrow to see what benefits he qualifies for.

C[redacted] RN, E[redacted] 9/28/2015 17:45 EDT

Following this meeting, they had another discussion with RN "K. B." and she said that she wasn't sure that she could help get him into the Hospital where she worked, but that as a last resort, they could order an ambulance and take The Patient to an Emergency Room, where they would have to at least examine The Patient. The Patient's Wife and "Sister TA" were hoping to find another more reasonable option.

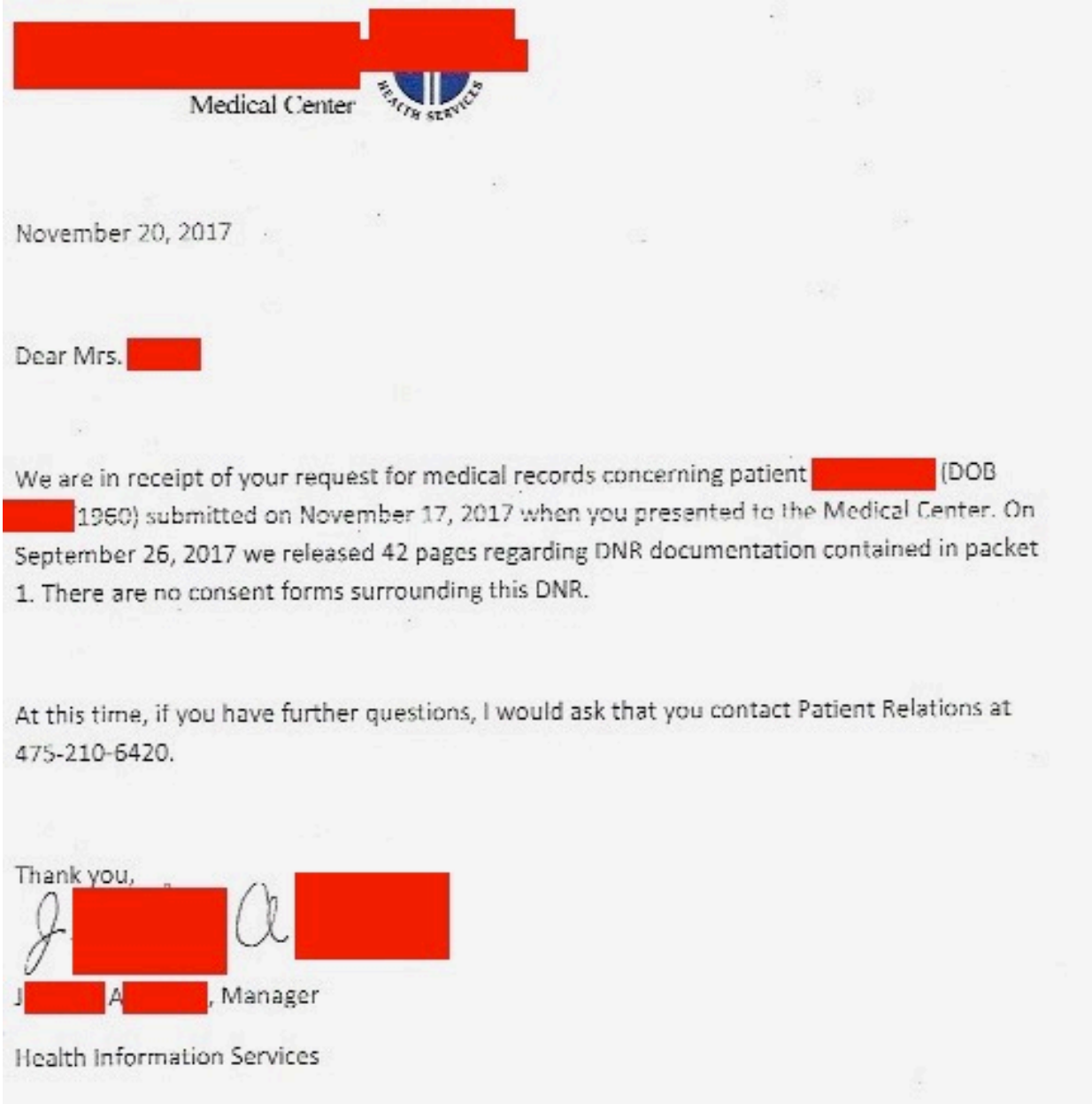
On October 2, 2015, The Patient was transferred to Ivy League Hospital and died a year later at a Convalescent Home near the Family's home.

<u>Record anomalies associated with this episode:</u>

In the records the Catholic Hospital sent to Attorney #1, the note detailing that The Patients Wife was upset was omitted. Fortunately, however, in the records sent to Attorney 2, someone forgot to take it out. Please see the records at the end of this document.

Also found in the records was "Dr O.F."'s 9/16/2015 discontinuation of "Dr R.F."'s order on 9/14/2015 which states Order Details..."DNR w/ interventions, Refer to Code Status Documentation, Spouse, no escalation of care, no mechanical vent, no pressers".

The Patient's Wife has asked for a copy of the Code Status Documentation and the Catholic Hospital responded that they do not have it.



[redacted] Medical Center

November 20, 2017

Dear Mrs. [redacted]

We are in receipt of your request for medical records concerning patient [redacted] (DOB [redacted] 1960) submitted on November 17, 2017 when you presented to the Medical Center. On September 26, 2017 we released 42 pages regarding DNR documentation contained in packet 1. There are no consent forms surrounding this DNR.

At this time, if you have further questions, I would ask that you contact Patient Relations at 475-210-6420.

Thank you,

[redacted]

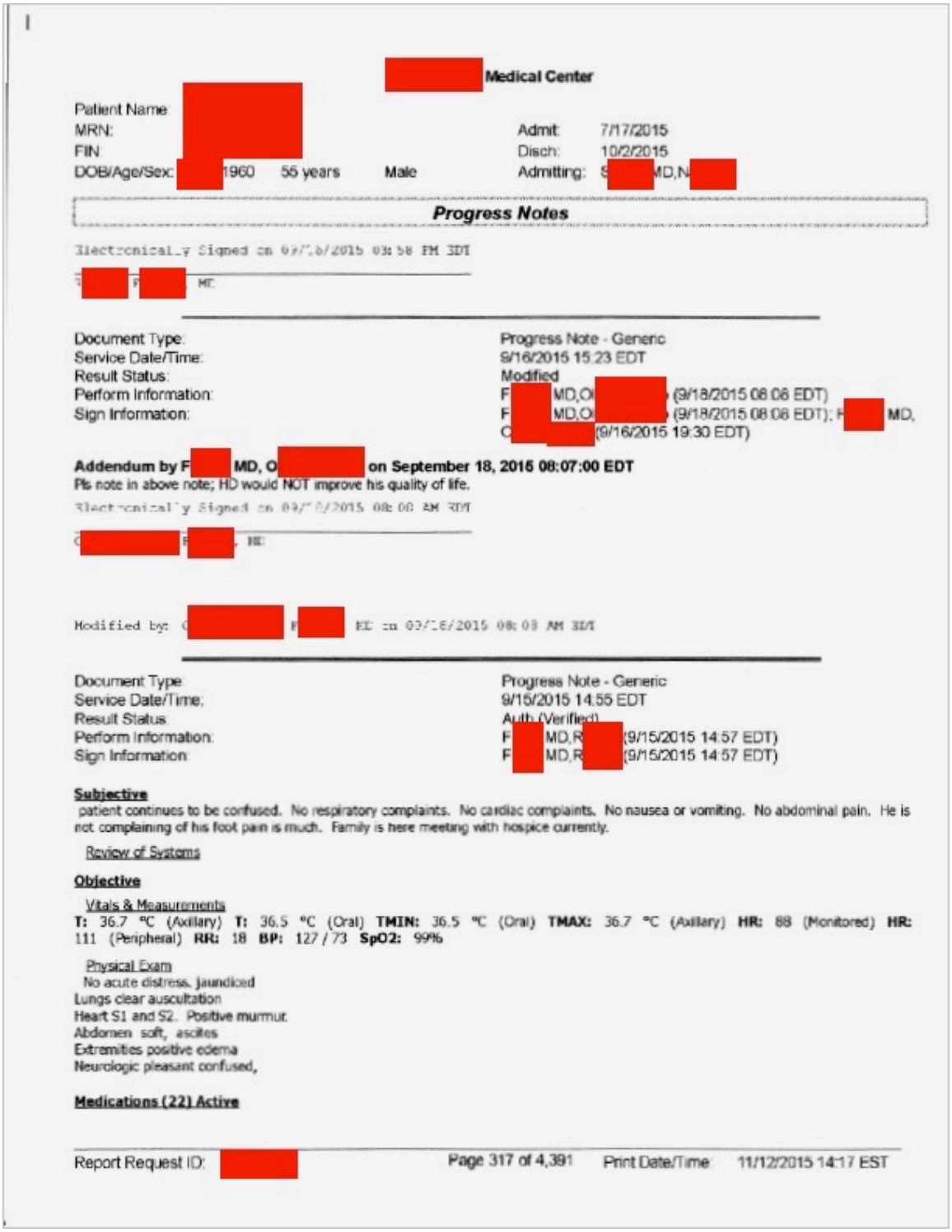
J[redacted] A[redacted], Manager

Health Information Services

In a curious turn of events, The Palliative Care doctor, "Dr R.F.", who ordered the unauthorized Code change, resubmitted a claim for services rendered during this time period to The Patient's Insurance Company. The original claim was submitted 9/14/15 (the day the Code change was made) and Insurance Company sent payment on 9/18/15. So it is unclear why the doctor resubmitted another

claim for the same amount and same date of service on 6/2/17, nearly two years later.

Attorney #1 Record



[redacted] Medical Center

Patient Name: [redacted]
MRN:
FIN:
DOB/Age/Sex: [redacted] 1960 55 years Male

Admit: 7/17/2015
Disch: 10/2/2015
Admitting: [redacted] MD,N[redacted]

Progress Notes

Electronically Signed on 09/16/2015 03:58 PM EDT
[redacted] MD

Document Type: Progress Note - Generic
Service Date/Time: 9/16/2015 15:23 EDT
Result Status: Modified
Perform Information: F[redacted] MD,O[redacted] (9/18/2015 08:06 EDT)
Sign Information: F[redacted] MD,O[redacted] (9/18/2015 08:06 EDT); H[redacted] MD, C[redacted] (9/16/2015 19:30 EDT)

Addendum by F[redacted] MD, O[redacted] on September 18, 2016 08:07:00 EDT
Pls note in above note; HD would NOT improve his quality of life.
Electronically Signed on 09/18/2015 08:08 AM EDT
[redacted] MD

Modified by: [redacted] MD on 09/16/2015 08:03 AM EDT

Document Type: Progress Note - Generic
Service Date/Time: 9/15/2015 14:55 EDT
Result Status: Auth (Verified)
Perform Information: F[redacted] MD,R[redacted] (9/15/2015 14:57 EDT)
Sign Information: F[redacted] MD,R[redacted] (9/15/2015 14:57 EDT)

Subjective
patient continues to be confused. No respiratory complaints. No cardiac complaints. No nausea or vomiting. No abdominal pain. He is not complaining of his foot pain is much. Family is here meeting with hospice currently.

Review of Systems

Objective

Vitals & Measurements
T: 36.7 °C (Axillary) **T:** 36.5 °C (Oral) **TMIN:** 36.5 °C (Oral) **TMAX:** 36.7 °C (Axillary) **HR:** 88 (Monitored) **HR:** 111 (Peripheral) **RR:** 18 **BP:** 127 / 73 **SpO2:** 99%

Physical Exam
No acute distress, jaundiced
Lungs clear auscultation
Heart S1 and S2. Positive murmur.
Abdomen soft, ascites
Extremities positive edema
Neurologic pleasant confused,

Medications (22) Active

Report Request ID: [redacted] Page 317 of 4,391 Print Date/Time 11/12/2015 14:17 EST

Attorney #2 Record

Assessment/Plan
Alcohol withdrawal syndrome
palliative care. End-stage liver disease. hepatorenal syndrome. Acute kidney injury. Encephalopathy. Continue current medical therapies. Case discussed with GI and hospitalist

Electronically Signed on 09/16/2015 03:58 PM EDT

[redacted] MD

Document Type: Progress Note - Generic
Service Date/Time: 9/16/2015 15:23 EDT
Result Status: Modified
Document Subject: Hospitalist note
Sign Information: [redacted] MD,O[redacted] 9/18/2015 08:08 EDT); F[redacted] MD, O[redacted] (9/16/2015 19:30 EDT)

Addendum by F[redacted] MD, O[redacted] on September 18, 2016 08:07:00 EDT
Pls note in above note; HD would NOT improve his quality of life.

Electronically Signed on 09/18/2015 08:08 AM EDT

[redacted] MD

Modified by: O[redacted] MD on 09/18/2015 08:08 AM EDT

Confused

Report Request ID: [redacted] Page 331 of 4,726 Print Date/Time: 1/10/2018 07:17 EST

[redacted]

[redacted] Medical Center

Patient Name: [redacted]
MRN: [redacted]
FIN: [redacted]
DOB/Age/Sex: [redacted]1960 57 years Male
Admit: 7/17/2015
Disch: 10/2/2015
Admitting: [redacted] MD,N[redacted]

Progress Notes

says no pain, abdomen better
understands he has liver disease

Exam
Oriented to only person
remains icteric
has reduced air entry in bases bilaterally
abd full, distended, dull pt percussion, non tender
bil pedal edema

Labs noted

Plan
55 yo a PMH mw, alcoholism, admitted in alcohol withdrawal, diagnosed in this admission with end stage liver disease> has since been inpatient with undulating alteration in mental status likely multifactorial, SBP X2 still on ciprofloxacin, now in hepatorenal syndrome
Have had an extensive discussion with his wife and sister today. They are concerned we are trying to withdraw care because he's been ill for so long.
I have clarified that we are here to support her and give [redacted] the therapies he needs as far as its in keeping with his goals of care
She has requested that we make him full code.
She clearly states - I know he is dying and he knows =, but we want to get as much time as possible for him.
She is extremely interested in HD, I have explained that there are 2 schools of thought on HD in HRS, She understands that it will improve his quality of life.
Paracentesis today for comfort and to confirm resolution of SBP
Resume lactulose to goal of 2-3 BMs /day
I suspect his encephalopathy is still multifactorial but likely being heavily contributed to by his rising BUN
Low K diet. Nutrition to see. Hes currently get both oral and tube feeds, TO go for swallow study in am.
Continue other meds

His wife was significantly agitated today. She wanted to transfer him to another hospital because she is worried we would withdraw care without notifying her.
I have adviced taking a short break from further goals of care conversations.
We will await definitive recs from renal and this would ultimately dictate his short term trajectory.

Electronically Signed on 09/16/2015 07:30 PM EDT

[redacted] MD

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