Quality of Hospital Comfort Care

Without Specialty Palliative Care Involvement

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PROBLEM STATEMENT

How often are comfort care orders placed, without involving palliative care (PC)?

What does that comfort care look like?

Are there any indications that this generalist/primary form of palliative care could benefit from specialist level referral or other changes to practices?

Could this method lead to a way to identify generalist/primary palliative care in research?

PROJECT DESCRIPTION

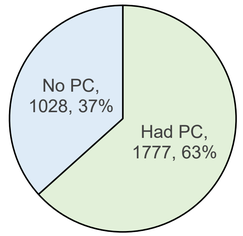
VCU IRB exempted this study in fall 2024 (HM20030806, HM20031248).

Data queries of VCU Health System data were performed of 2,805 hospitalized patients Dec 2021 – Sept 2024 with Do Not Attempt Resuscitation / Comfort Care Only (DNAR/CC) code status orders who were (now) known to be deceased.

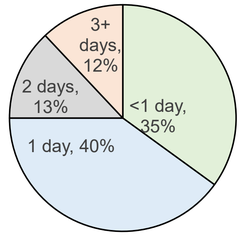
330 cases had length of stay of 5-15 days who did not have specialty palliative care or inpatient hospice previously, concurrently, or subsequent to that hospital stay. Chart reviews were performed on a 137 of those cases: All 89 that had at least 1 night in the hospital after DNAR/CC order, and 48 of the 194 who were discharged or died same day as the DNAR/CC order (saturation of information was quickly achieved).

RESULTS

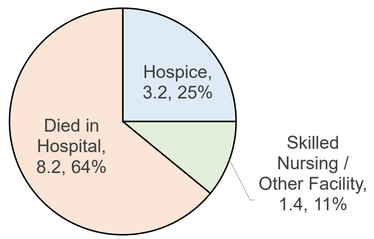
Received Palliative Care?



LOS after DNAR/CC



Disposition



About one-third of the DNAR/CC cases in the hospital did not have specialty palliative care involvement; we verified this with subsequent reviews of a sample of cases. This may be a viable method for identifying generalist/primary palliative care in hospitals.

Of the 137 cases reviewed manually:

- Admitted to a number of units and teams in hospital:
  - 23% Pulmonary/Critical Care
  - 22% Hospital Medicine
  - 13% Cardiology
  - 11% Oncology
- 75.2% of cases had no discussion of potentially involving palliative care team
- 14.6% of patients received therapies outside the scope of comfort care, including lab tests and continuation of vasopressors.
- Most cases had little or no documentation of symptom burden
- None had Physician Order for Life-Sustaining Treatment (POLST) forms or other Advanced Care Planning (ACP) documentation at time of transition to Comfort Care.

Case example: A >75-year-old woman with atrial fibrillation and prior stroke was admitted with acute right-sided weakness and aphasia due to an occlusion of a cerebral artery. She underwent mechanical thrombectomy, requiring intubation and transfer to the neurosurgical ICU. She was extubated two days later but remained dependent on high-flow nasal cannula for oxygen support. Despite attempts, she was unable to tolerate weaning. Her limited ability to swallow necessitated placement of a Dobhoff tube. An MRI confirmed an acute infarction of the basal ganglia, and she continued to demonstrate right-sided deficits, aphasia, and encephalopathy. After discussions with her family, her code status was transitioned to DNAR/comfort care.

After this transition, however, she continued to receive multiple chronic medications for two days, including aspirin, amlodipine, atorvastatin, fenofibrate, furosemide, losartan, and metoprolol succinate. She also underwent a chest x-ray two hours after the change in goals of care. These interventions provided no symptomatic benefit and represented care that was inconsistent with her stated wishes and goals of care.

DISCUSSION

About 30 patients/month in our hospital go on DNAR/CC code status and are not referred to palliative care. Of charts reviewed manually, about 15% received care that could be considered inconsistent with “comfort care” principles. Documentation of symptoms was rare, as was use of POLST or ACP documentation upon transition to DNAR/CC.

There are significant opportunities to standardize practices across the hospital in generalist/primary comfort care practice, which often stretches to several days before death or discharge. These may explore ways to improve documentation and possibly introduce a uniform template for goals of care for the remainder of hospitalization and via POLST into a post-acute care setting. Future projects may focus on addressing gaps in symptom burden documentation and reducing lab tests when patients transition to comfort care.

“Comfort care” cases are geographically dispersed in our hospital; quality improvement practices should be implemented broadly. Whatever form these quality improvement activities take, our goal is to empower hospital teams to provide standardized high-quality primary PC and not necessarily increase referrals to the PC team.

INSIGHTS

Researchers may consider use of the “Z51.5 Encounter for Palliative Care” ICD10 code or DNAR/CC code status orders in the absence specialty PC team involvement to identify generalist/palliative care activity. This has been difficult to define/identify in secondary datasets.

While hospital-PC was to some extent an effort to replace unstandardized “comfort care” in hospitals with evidence-based, standardized practices, in our hospital the two continue to exist side by side.