Comfort Care in the Neonatal Intensive Care Unit: Screening for Patient Eligibility

Executive Summary of Quality Improvement Project

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What is Comfort Care? Why is determining patient eligibility important?

- This DNP quality improvement project focused on establishing a consistent method for initiating Comfort Care services within a Level 4 Neonatal Intensive Care Unit (NICU) through the implementation of a diagnosis-based screening tool to determine patient eligibility.
- Comfort Care, or Palliative Care, is a multidisciplinary approach focused on optimizing the quality of life of patients facing life-threatening or life-limiting conditions, with the option to continue concurrent delivery of curative interventions.
- A standardized screening process has the potential to facilitate timely delivery of physical, social, emotional, and spiritual supportive services.
- A standardized tool was not found to increase the number of completed consults for eligible patients by the desired 50% during the implementation period. However, periods of time with a consistent increase in team member communication reflected a positive increase in the number of completed consults for eligible patients.

Background and Purpose

Patients within a Neonatal Intensive Care Unit (NICU) facing a life-limiting or life-threatening condition require consistent management of specialized medical care in addition to diligent coordination of supportive services. A standardized approach to delivering care supports timely identification of patient needs, increased service utilization, and effective team communication. Comfort Care, or Palliative Care services are designed to meet the physical, emotional, social, and spiritual needs of the patient and family during their hospitalization (National Association of Neonatal Nurses, 2015).

The American Academy of Pediatrics (2000), the National Association of Neonatal Nurses (2015), and the World Health Organization (2020) support the development of Comfort Care, or Palliative Care programs that promote quality of life and alleviate suffering. Historically, decisions and interventions related to neonatal Comfort Care, or Palliative Care have been shaped by a provider's clinical judgment

and past experiences with dying patients rather than established standards (Thibeau & Naquin, 2012). A level four NICU in eastern North Carolina serving an average of 1,100 newborns annually has the resources to implement supportive services characteristic of Comfort Care, or Palliative Care, yet it does not have a standardized process for identification of eligible patients or initiation of the Comfort Care consult process (East Carolina University, n.d.).

The cultural preference of the project site is for supportive services to be classified as Comfort Care, although curative interventions often coexist. This is to reduce parental fear of abandonment and consistently use language that promotes comfort and wellbeing. For the purposes of this project, both terms will be used interchangeably. This quality improvement (QI) project utilized a diagnosis-based screening tool to promote consistent identification of patients who would benefit from a Comfort Care consult and services subsequently offered. The aim of the QI project was to increase the number of Comfort Care consults performed in the Neonatal Intensive Care Unit (NICU) for eligible patients by 50% at the project site during the implementation period in comparison to the baseline period.

Methodology

The diagnosis-based eligibility screening tool was made available for use to all clinical staff to screen all NICU patients receiving inpatient medical care. Prior to the project implementation, education on the project's background, purpose, and tool was provided at unit staff meetings and during daily morning team huddles. A Plan-Do-Study-Act framework was utilized to implement this project within a 50-bed NICU. Three cycles were conducted over a 12-week implementation period, with each cycle lasting four weeks. During each PDSA cycle, meetings were held with the unit's Comfort Care team and the project site champion to assess facilitators and barriers to tool usage. Additional education materials for NICU staff were made available directly on unit communication boards and by uploading to the unit's educational resource system. Nursing staff surveys were conducted during the final PDSA cycle to

evaluate bedside nursing staff feelings and beliefs regarding Comfort Care services and the process of identifying eligible patients.

Eligible patients during the baseline period (calendar months of 2025 prior to implementation period) and the implementation period were identified by reviewing raw data from the Vermont Oxford Network (VON). The Vermont Oxford Network is operated by a worldwide interdisciplinary team dedicated to sharing data specific to neonates for the purpose of improving quality of care and advancing standards of care amongst the neonatal population (Vermont Oxford Network, n.d.). The VON data categories under which patients were identified as being eligible for inclusion in this QI project were "disposition of death" (life-threatening diagnosis), "22 and 23 weeks' gestation" (life-limiting diagnosis), and "grade 3 / grade 4 intraventricular hemorrhage" (life-limiting diagnosis). Manual chart reviews were performed to determine if eligible patients received a Comfort Care consult or any related supportive services during their hospitalization. Supportive services included Child Life, Pastoral Care, and Child and Adolescent Psychology. The data was recorded on a Microsoft Excel spreadsheet.

Results

The percentage of eligible patients who received Comfort Care consults during the implementation period was the outcome measure recorded for each patient category. Of the patients with a disposition of death, 7 out of 27 (26%) received a Comfort Care consult during the baseline period in comparison to 0 out of 4 (0%) during the implementation period. Of the patients diagnosed with extreme prematurity (22 to 23 weeks' gestation at birth), 2 out of 8 (25%) received a Comfort Care consult during the baseline period in comparison to 1 out of 3 (33%) during the implementation period. Of the patients diagnosed with grade 3 / grade 4 intraventricular hemorrhage (IVH), 3 out of 22 received a Comfort Care consult during the baseline period in comparison to 1 out of 4 (25%) during the implementation period. The number of Comfort Care consults completed for eligible patients did not increase by the desired 50% during the project implementation period. Of note, 4 out of the 7 Comfort

Care consults completed during the baseline period for patients with a disposition of death, took place immediately prior to implementation of the first PDSA cycle when staff education and provider communication were at their peak in preparation for project rollout.

Following data observation, the effects of screening tool application on supportive service utilization rates remained unclear. Supportive service team members operate within the Children's Hospital independently and therefor do not require a Comfort Care consult to be completed prior to establishing contact with patients and their families. Nursing staff surveys revealed bedside nursing staff as being in favor of establishing a standardized Comfort Care process that aligned with NANN recommendations; 71% of bedside nursing staff reported feeling comfortable being involved in identifying patients eligible for Comfort Care services, while 93% of bedside nursing staff reported being in agreement with Comfort Care consults being conducted at time of diagnosis.

Strengths and Limitations

Having an established Comfort Care team committed to providing high quality care at the project site encouraged screening tool use and facilitated delivery of already existing supportive services. NICU staff's accessibility to the Comfort Care screening tool and related educational materials promoted familiarity, continued education, and multidisciplinary communication. Unit initiatives focused on promoting quality of life for patients and their families inspired continued project partner interest in successful project implementation and future recommendations. Accessibility to raw VON data and patient charts for manual review facilitated a detailed assessment during data collection period.

In contrast, the lack of an actionable step in the electronic health record system at the time of screening for patient eligibility was identified as a barrier to consistent tool use despite the screening tool always being readily available. This barrier was observed to negatively affect multiple aspects of project implementation including consistent screening tool use and documentation. Despite the screening tool's instructions to assess for eligibility at time of diagnosis and guidance on which

conditions were considered eligible, the tool did not appear to influence the time efficiency with which Comfort Care consults took place. Lastly, the nature of the fast-paced intensive care environment with a sizeable nursing staff group, underlined the need for continued education to ensure a shared understanding of Comfort Care and Palliative Care principles.

Future Implications

Times of increased team communication were observed to be a strong proponent for increased screening tool utilization, indicating that the presence of a dedicated team member or Comfort Care coordinator could be beneficial in increasing Comfort Care consult rates for eligible patients, decreasing provider and NICU staff workload, and increasing opportunities for unit education. Furthermore, the presence of a dedicated Comfort Care coordinator would encourage adherence to a standardized process and consistent follow-up of patient needs and care goals.

Conclusion

Delivery of Comfort Care, or Palliative Care services to eligible NICU patients and their families ensures that they receive the compassionate, holistic care necessary to minimize suffering and optimize quality of life in the face of a life-limiting or life-threatening diagnosis (Catlin & Carter, 2002). Initiation of this process relies on accurate and timely patient identification and initiation of services. Successful implementation of this step would contribute positively to the goals of improving infant health by addressing social determinants of health and correcting health disparities supported by Healthy People 2030 (n.d.) and the NC Institute of Medicine (Lyda-McDonald, 2020).

References

American Academy of Pediatrics Committee on Bioethics and Committee on Hospital Care. (2000). Palliative Care for Children. *Pediatrics, 106*(2), 351–357.

Catlin, A., & Carter, B. (2002). Creation of a neonatal end-of-life palliative care protocol. *Journal of Perinatology, 22*(3), 184 – 195. https://doi.org/10.1038/sj.jp.7210687

East Carolina University Division of Neonatology and Newborn Medicine. (n.d.) *Neonatal Intensive Care Unit.* https://neonatology.ecu.edu/neonatal-intensive-care-unit/

Lyda-McDonald, B. (2020, June). Clinical care recommendations of the perinatal system of care task force aim to reduce maternal and infant health disparities in North Carolina. NC Institute of Medicine. https://nciom.org/clinical-care-recommendations-of-the-perinatal-system-of-care-task-force-aim-to-reduce-maternal-and-infant-health-disparities-in-north-carolina/

National Association of Neonatal Nurses. (2015). Palliative and end-of-life care for newborns and infants position statement #3063. *Advances in Neonatal Care, 15*(4), 239 – 240. https://doi.org/10.1097/ANC.0000000000000215

Office of Disease Prevention and Health Promotion. (n.d.) *Healthy people 2030: Infants*. U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/infants

Thibeau, S., & Naquin, L. (2012). NICU perspectives on palliative care. *The Journal of Continuing Education in Nursing, 43*(8), 342–343. https://doi.org/10.3928/00220124-20120725-03

Vermont Oxford Network. (n.d.) *Who we are.* https://public.vtoxford.org/who-we-are-overview/

World Health Organization. (2020, August). *Palliative Care*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/palliative-care