PCQC Palliative Care Quality Collaborative

COVID-19 Palliative Care Case Report
Hospital-Based Survey
For additional information visit PalliativeQuality.org

**Patient identifying information is not asked on the case report but could be helpful if you need to return to this form multiple times.

Medical record #: _____ Last name: _____

(1) Which area of the country is your palliative care program located?
☐ US West ☐ US Midwest ☐ International (outside US) please
☐ US South ☐ US Northeast specify _____

(2) What type of organization is your program's Administrative Home? *If neither of these options apply please see the community-based form
☐ Hospital
☐ Health System

(3) Please select the category that best describes the patient's location during this visit. *If the location is not included in the list, please select "other" and add the location. For those patients seen via telemedicine indicate the location where palliative care is primarily provided*
☐ Hospital- General Floor (includes step-down, pre-op)
☐ Hospital – ICU (includes MICU, SICU, TICU, CICI, Neuro ICU, PICU)
☐ Hospital Palliative Care Unit
☐ Emergency Department
☐ Outpatient (Clinic)
☐ Other: _____
☐ Long term care (includes LTAC, SNR, NH)
☐ Assisted Living Facility
☐ Other Domiciliary
☐ Home
☐ Unknown

(4) How did you see the patient?
☐ Bedside/ in person
☐ By telemedicine
☐ By phone
☐ E-consult/curbside/ chart rec

(5) What is the patient's age?
☐ Under 1 ☐ 35-49 ☐ 80+
☐ 1-18 ☐ 50-64 ☐ Unknown
☐ 19-34 ☐ 65-79

(6) What is the patient's current gender identity?
☐ Female ☐ Non-Binary
☐ Male ☐ Decline to Say
☐ Transgender Male/ Female-to-Male (FTM) ☐ Prefer to Self-Describe
☐ Transgender Female/ Male-to-Female (MTF) ☐ Unknown

(7) What is the patient's current COVID-19 diagnosis?
☐Under investigation/ Suspected
☐ Confirmed
☐ Recovered
☐ Unknown

(8) Please select the referring specialty that generated the palliative care consult for this patient. If the referring service is not included in the list, select "other" and then specify the service
☐ General Medicine (e.g., family medicine, internal medicine)
☐ Hospital Medicine
☐ Hematology
☐ Cardiology
☐ Oncology (includes medical oncology, hematology oncology, Radiation oncology, surgical oncology)
☐ Neurology
☐ Pulmonary
☐ Critical Care (includes MICU, SICU, TICU)
☐ Other Internal Medicine Subspecialty (e.g., GI, Nephrology, Rheumatology, Geriatrics)
☐ Self (Palliative Care Team)
☐ Surgical Specialties
☐Emergency Medicine
☐ Other, please specify: _____

(9) Please select the diagnosis category that best reflects the patient's primary underlying serious illness in addition to COVID-19. If the patient was previously well, please mark none.
☐ None (patient was previously well with no serious illness)
☐ Cancer (solid tumor)
☐ Cancer (Heme)
☐ Cardiovascular
☐ Pulmonary
☐ Gastrointestinal
☐ Hepatology
☐ Renal
☐ Dementia
☐ Neurology (includes Neuromuscular or non-dementia Neurodegenerative)
☐ Infectious
☐ Trauma
☐ Vascular
☐ Metabolic/Endocrine
☐ Genetic/ Chromosomal
☐ Hematology (non-cancer)
☐ Prematurity/ Complications related to prematurity
☐ Fetal
☐ Unknown
☐ Other: _____

(10) Please select the palliative care team members involved in the care of the patient. Select all that apply. The discipline must be a regular and specifically recognized member of the palliative care team and must have contact with the patient/family. The person of that discipline may have other responsibilities but is clearly identified and identifies as a member of the palliative care team. For example, a visit by a chaplain that sees all patients in the hospital but who does not participate as a member of the palliative care team would not be included. If that chaplain did attend palliative care team meetings (clinical and administrative), then the chaplain would be considered a member of the palliative care team, and the visit would be recorded here. Check all that apply
☐ Physician ☐ Licensed Practical Nurse (LPN) ☐ Chaplain/ Spiritual Care ☐ Dietitian/ Nutritionist
☐ Advanced Practice Nurse ☐ Psychologist ☐ Physical/ Occupational Therapist ☐ Pharmacist
☐ Physician Assistant (PA) ☐ Psychiatrist ☐ Other Therapist (e.g., massage, music/art) ☐ Community Health Worker
☐ Registered Nurse (RN) ☐ Social Worker ☐ Child Life Specialist ☐ Other: _____

(11) Please select the reason(s) for the palliative care consultation at the time of the initial request (check all that apply)
☐ Symptom Management ☐ Decision Making (includes Goals of Care) ☐ Appoint health care proxy ☐ Providing support to patient/family
☐ Providing support to colleagues/staff ☐ Other: _____

(12) What did the palliative care team help with?

Symptom Management
- ☐ Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Excess Secretion
- ☐ Restlessness
- ☐ Anxiety
- ☐ Agitation/ delirium
- ☐ Depression

Decision Making/ Goals of Care
- ☐ Appointing health care proxy/surrogate
- ☐ Discussing GOC with patient
- ☐ Discussing GOC with proxy/surrogate
- ☐ Discussing decisions to not start or stop life-sustaining treatment
- ☐ Other: _____

Providing Support
- ☐ Providing support to patient/family
- ☐ Providing support to colleagues/staff

(13) What was the formally indicated status of the patient with respect to the desire for resuscitative efforts? Formally indicated status implies signed documents are present that describe the patient's code status.

At time of consult:
- ☐ Full
- ☐ DNR, not DNI
- ☐ DNR/DNI (DNAR + AND)
- ☐ Unknown

At the time of discharge:
- ☐ Full
- ☐ DNR, not DNI
- ☐ DNR/DNI (DNAR + AND)
- ☐ Unknown

(14) Patient status at the time of the palliative care sign-off from the inpatient team
- ☐ Alive
- ☐ Died

(15) If your patient died, was family allowed to be physically at the bedside?
- ☐ Yes
- ☐ No

(16) If your patient died, was the family able to communicate with the patient by phone or video conference?
- ☐ Yes
- ☐ No

(17)What challenges, lessons learned, or ethical barriers did you encounter in caring for this patient? Please do not include any patient identifiable information in your response.