Materials used in the BEACON Implementation Trial

Best practices for **E**nd of life care **A**nd **C**omfort care **O**rder sets for our **N**ation's veterans

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Introduction to the BEACON Comfort Care Order Set

Purpose of the Comfort Care Order Set

The Comfort Care Order Set (CCOS) was developed as a decision support tool to improve the processes of end-of-life care for veterans dying in either the acute care wards or nursing home units (Community Living Centers (CLC)) of VA Medical Centers. Annually, in the United States, approximately 3 out of 4 deaths occur in institutional settings, with close to 50% of all deaths taking place in acute care hospitals and nearly 25% occurring in nursing homes. Although hospice is widely available, each year the number of home hospice deaths remains a minority, and it is unlikely that this will change in the foreseeable future. Therefore, it is important to optimize the provision of end-of-life care in acute and long-term institutional settings where the majority of deaths occur.

Research has demonstrated that end-of-life care in acute care and nursing home settings often is associated with unmet needs for pain and non-pain symptom control and assistance with social, emotional, and spiritual distress of both the patient and family. In addition to inadequate symptom recognition and management, iatrogenic suffering frequently results from routine medical care, such as IV infusions, blood work, testing, and monitoring that no longer benefits the dying patient. The CCOS has been carefully devised, based on best practices of care for the dying in home hospice.

The CCOS guides clinicians in changing the processes of end-of-life care and ensuring access to medications for symptom control. This is coupled with changes in all aspects of nursing and personal care. Appropriate disease managing therapies can be continued, while at the same time reducing restrictions and avoiding testing and treatments, when the burdens of these procedures outweigh the benefits. In this way, adopting the CCOS can enhance both the quality and quantity of life for our patients by individualizing care plans that take advantage of the resources of institutional care.

Evaluation of the Comfort Care Order Set

The CCOS has been evaluated extensively. First, the components of the CCOS were compared with the practices and recommendations for provision of care for the dying patient in home settings. Second, each intervention component was evaluated individually for effectiveness, safety and application for individual physical symptoms.

The CCOS was tested for practical application at the Birmingham VAMC by evaluating its impact on processes of care for patients who died before and after implementation of the CCOS. Positive results included a marked increase in the number of patients for whom an opioid was ordered, as well as an increase in the number of veterans who received some opioids in the last 72 hours of life (from 13-72%). Effects on non-pharmacological processes included increases in documented goals of care and family presence at time of death, as well as reduction of deaths in

the ICU and reduced use of instrumentation. The practical application of the CCOS was also evaluated by observing medical providers using it. Modifications were made to improve ease of use and to encourage integration of the entire packet of the CCOS into care plans.

Review and observation of the end-of-life care provided by nurses, pharmacists, respiratory therapists, dieticians, and all other providers in the hospital revealed how they interpreted the CCOS in relation to their roles. Input from front-line providers identified barriers and concerns that were subsequently addressed through modifications, deletions, and additions to the CCOS. This work highlighted the importance not only of changing orders for processes of care, but also changing the culture of the facility. Educating and nurturing buy-in from the medical providers who order the CCOS, as well as those who implement the orders, is essential to ensuring that excellent end-of-life care is the institutional norm.

As of the end of 2013, the CCOS system was installed and tested at more than 20 VA Medical Centers.

Practical Application

- The CCOS is a decision support tool with education and explanatory notes within each section to facilitate utilization. This includes guidance to consider the burdens and benefits of all interventions and orders, including both those in the CCOS and those already in place.
- The CCOS can be used by any clinician with the authority to write orders. Expertise in Palliative Medicine is not required.
- The CCOS can be used to plan care in any location within the medical center.
- The CCOS may be used to initiate symptom control for a consult while the patient remains on the current service. In this situation the CCOS serves as a tool for educating non-palliative care providers about symptom management.
- Clinicians may use all or part of the CCOS. They may wish to use only one section, such as the guidelines for treating delirium, to provide timely relief for patients in the ICU or some other setting.
- Some non-palliative care providers may decide to use parts of the CCOS to assist them with setting up a symptom control care plan independent of the Palliative Care specialist and/or before the Palliative Care team can see the patient in consultation.
- Palliative Care providers often use the CCOS to admit or transfer patients to their Hospice/Palliative Care service.
- Providers may open the CCOS to initiate some components, and return to the CCOS at a later time to refine the plan.

- The CCOS does not require the modification or discontinuation of disease modifying orders or treatments (such as change in resuscitation status to DNAR). To complement or supplement the current treatment plan, the CCOS can be layered onto existing disease modifying orders so the overall care plan aligns with the patient's goals of care.

- It is good practice to review all medications and orders on a regular basis to update orders and reconcile care plans with evolving goals of care.

The Importance of Providing Education

It is important to have an education plan for clinicians who will be using the CCOS to place orders and for other team members who routinely carry out care plans.

Clinicians who will be using the CCOS to write orders need to understand where the order set is located and how to navigate the system to place orders. There may be a small core of clinicians who will use the order set routinely. These clinicians may be members of a Palliative Care team or work on a specific hospice or palliative care unit. Often, they can become educators.

Other clinicians may use the CCOS infrequently and/or with the assistance and guidance of the Palliative Care team. A physician working in the Emergency Unit or a hospitalist on an impatient ward service or other location may need to use the CCOS to initiate symptom management before the Palliative Care team can provide a comprehensive evaluation and recommendations.

Because the CCOS affects all aspects of end-of-life care, it is important that all providers have some understanding of the program and how it may affect their area of patient care expertise. To support implementation of the CCOS, it is important for education to include nursing staff, respiratory therapists, dieticians, pharmacists, and any other providers for patients for whom a CCOS may be used.

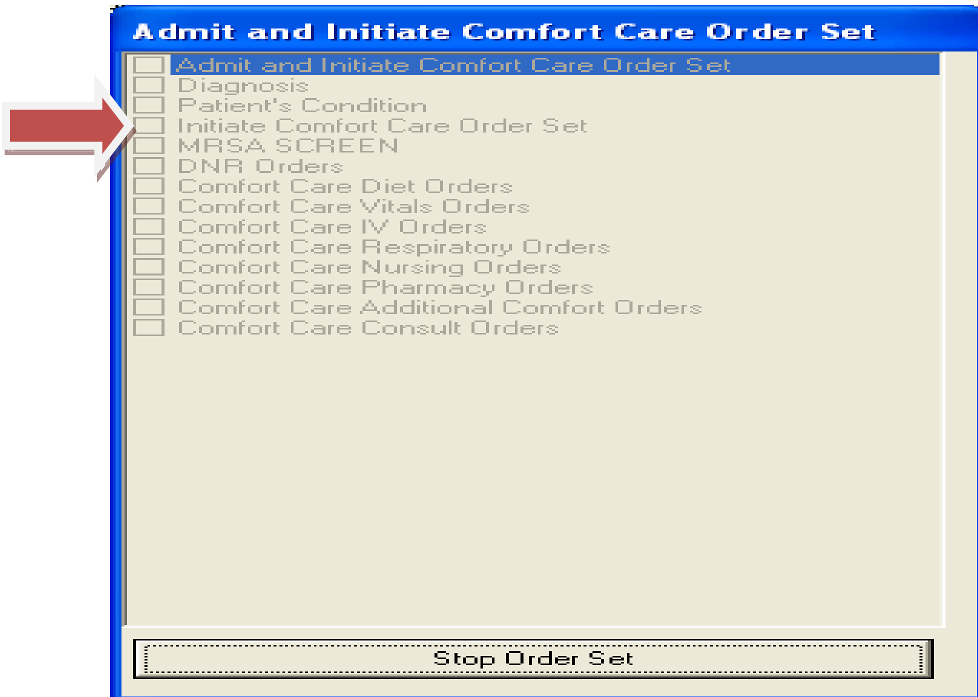
For example, nursing staff may be need to use subcutaneous lines, or the "offer may refuse" opioid order, rather than only IV or PO medications. Pharmacists may be unfamiliar with the use of sublingual morphine concentrate, because it has not been used previously in their facility. Dietary providers may not understand why a patient with a history of diabetes is permitted to have ice cream. Respiratory therapists need to understand that, for some patients, it may be more comfortable to use nasal cannula, instead of a face mask when patient comfort is the goal of care.

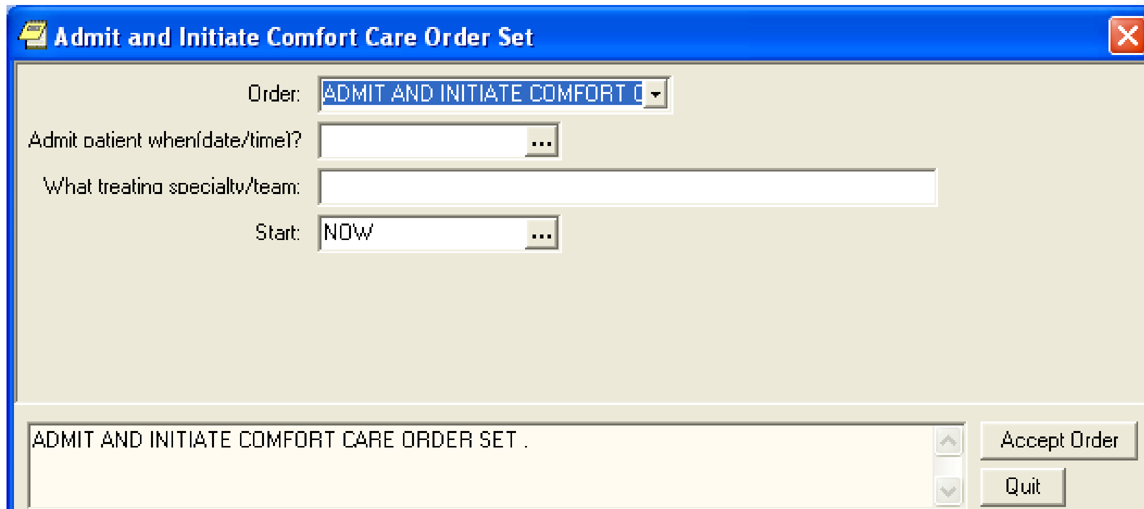
Staff education helps everyone understand how the CCOS concept works, how orders may be different from the usual routine, and the need for integration of the CCOS into the culture of the facility. To maintain consistency in provider knowledge, if the medical center has physicians in training (medical students, residents) who rotate through the hospital, their orientation program should include an introduction to the CCOS.

Sections of the Comfort Care Order Set

Section 1: Admit & Initiate Comfort Care Order Set

The "Admit and Initiate Comfort Care Order Set" section is used to initiate CCOS as part of the plan of care in any location in the medical center. For patients remaining in their current ward and bed section, the provider would start with "Initiate Comfort Care Order Set." (See the arrow below)





Diagnosis

Diagnosis:

Diagnosis :

Accept Order

Quit

Patient's Condition

Order: CONDITION

Enter condition:

Start: NOW

Stop: T+60

CONDITION :

Accept Order

Quit

Section 2: Transfer & Initiate Comfort Care Order Set

Transfer and Initiate Comfort Care Order Set

- Transfer & Initiate Comfort Care Order Set
- Diagnosis
- Patient's Condition
- Initiate Comfort Care Order Set
- DNR Orders
- Comfort Care Diet Orders
- Comfort Care Vitals Orders
- Comfort Care IV Orders
- Comfort Care Respiratory Orders
- Comfort Care Nursing Orders
- Comfort Care Pharmacy Orders
- Comfort Care Additional Comfort Orders
- Comfort Care Consult Orders

Stop Order Set

Transfer & Initiate Comfort Care Order Set

Order: TRANSFER & INITIATE COMFORT

Date/time for transfer:

Required Statement: I have discussed the transfer of this patient with the following Attending Physician who has completely concurred with this action.

Attending physician:

Transfer patient to:

Stop: T+14

TRANSFER & INITIATE COMFORT CARE ORDER SET :
Transfer validation: I have discussed the transfer of this patient with the following Attending Physician who has completely concurred with this action.

Accept Order

Quit

The remainder of the transfer order set is identical to the admission order set.

Section 3: DNR/DNI Orders

This section prompts providers to document and place orders reflecting the patient's current Advance Care Plan and resuscitation preferences.

DNR Orders — Next

Per Policy Resident DNR/DNI order active X 24hr after discussing with Attending

DNI X 24 HOURS (RESIDENT ORDER)

DNI ATTENDING ORDER

DNR X 24 HRS (RESIDENT ORDER)

DNR ATTENDING ORDER

REMOVE DNI (REMOVES DNI POSTING FROM COVER SHEET)

REMOVE DNR (REMOVES DNR POSTING FROM COVER SHEET)

Section 4: Diet Orders

Full liquid diet is the default setting. This section also includes orders for encouraging family to engage the patient in pleasure eating/feeding through provision of favorite foods.

Comfort Care Diet Orders — Next

DIET: Patient may improve and desire to taste food.
Order full liquid instead of clear liquid. More palatable.
Easier to swallow. Less likely to cause aspiration. Advance as tolerated.

1 Diet / Nutrition Orders

2 Full Liquid Diet

3 May have food brought in by family

4 Allow patient to sit up for meals. Assist to eat.

Section 5: Nursing Orders

This section includes orders that promote patient comfort and safety, facilitate environmental modifications to reduce or prevent delirium, and encourage family presence and assistance.

Comfort Care Nursing Orders — Next

NURSING:

TIPS FOR COMFORT/SAFETY:
Comforting measures. Reposition. Massage. Speak to patient.
Soft music. Avoid sensory overload (TV).

1 Please weigh on admission to Safe Harbor and weekly on Mondays thereafter
2 For CHF please weigh daily
3 May discontinue lab tests and daily wts and SCD's and subq Heparin and discontinue telemetry
4 RN may change form of medicine and route of administration. No IM meds
5 Keep hearing aid and dentures and glasses on pt.
6 Audiology consult:obtain amplifier for HOH patient

ACTIVITY: AVOID RESTRAINTS. Patient may need one on one sitter.

Begin environment modifications:

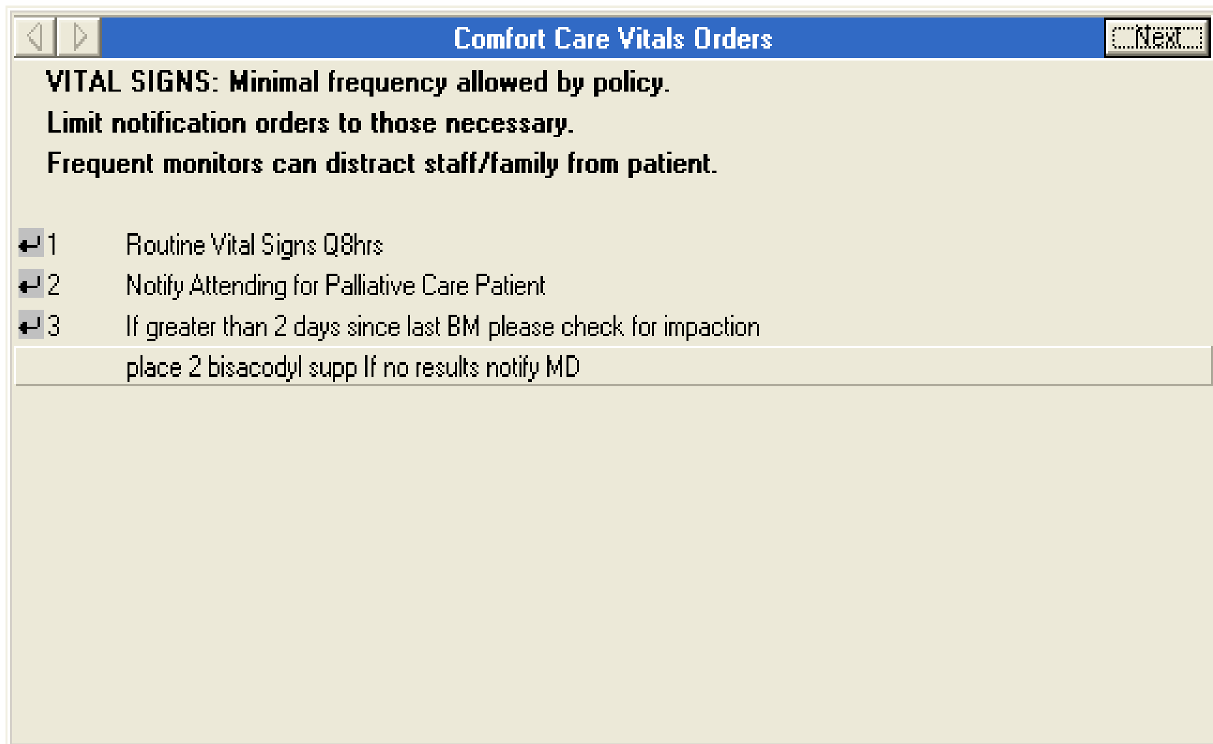
7 OOB to chair BID and preferably outside
8 Open curtain during day.
9 Decrease unnecessary noise (turn off TV)
10 Redirect ~ Reposition ~ Speak quietly
11 Provide nightlight when sleeping.
12 Please allow family to stay with patient in room

ASSISTING FAMILY:
Advise family about alerting their family members as to gravity of pt status. Arrange family visits of military relatives by contacting Red Cross and of incarcerated relatives by contacting warden. SW may assist.

12 Please give family "Preparing For Your Loved One's Loss"

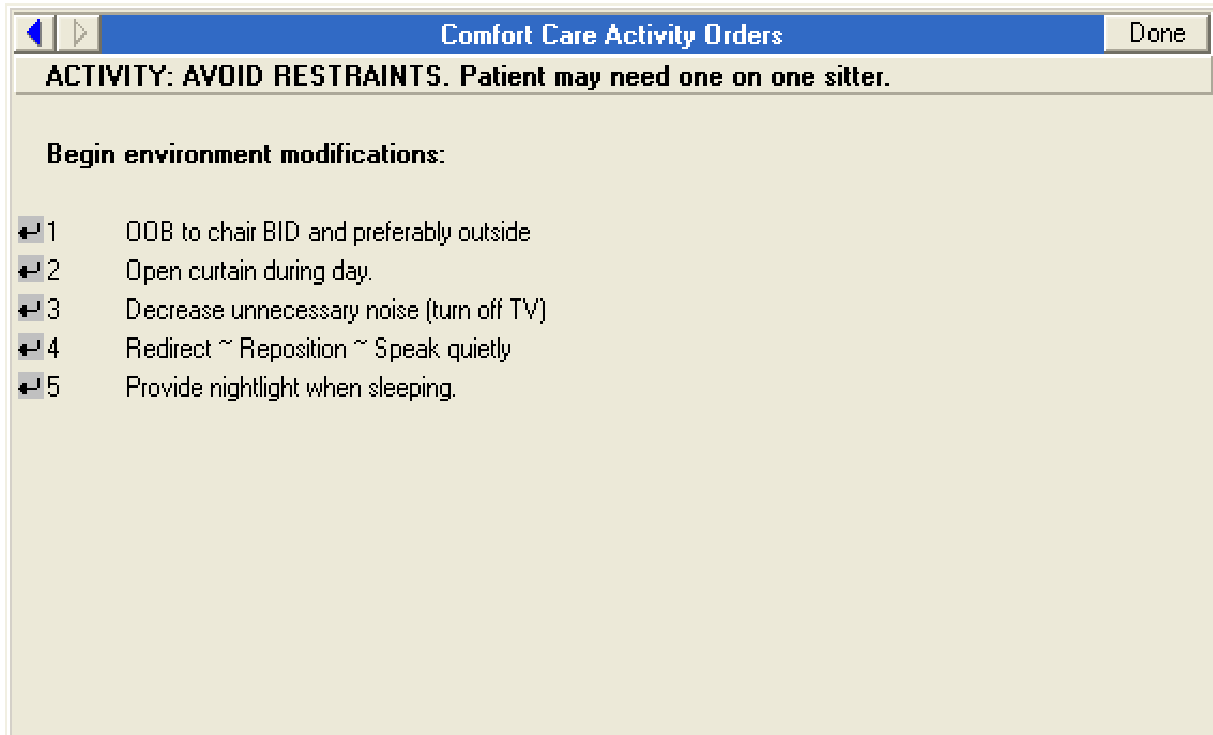
Section 6: Vital Signs

Vital sign orders allow for customization of vital sign monitoring that de-emphasizes frequency and refocuses on symptom assessment, comfort, and effectiveness of interventions. The call-back parameters are based on control of symptom assessment rather than specific numbers.



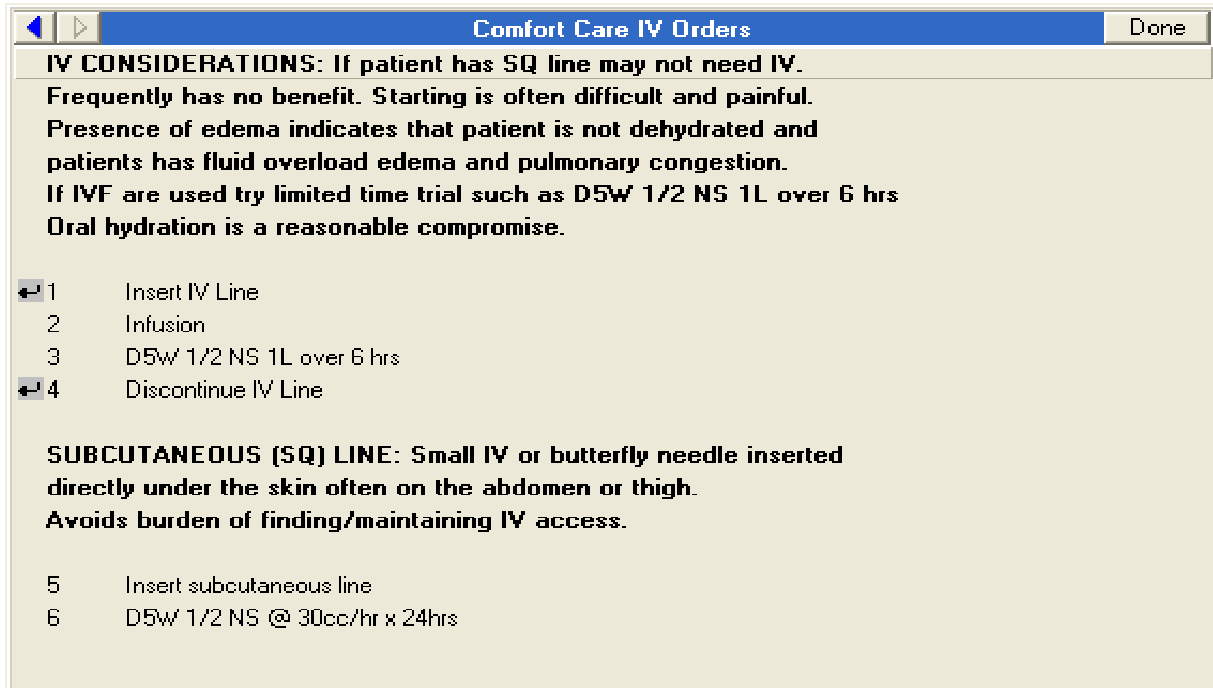
Section 7: Activity Orders

This section includes orders for environmental modifications to reduce or prevent delirium and that encourage patient, family and staff to facilitate activity and positioning that maximizes patient comfort, safety, and choice.



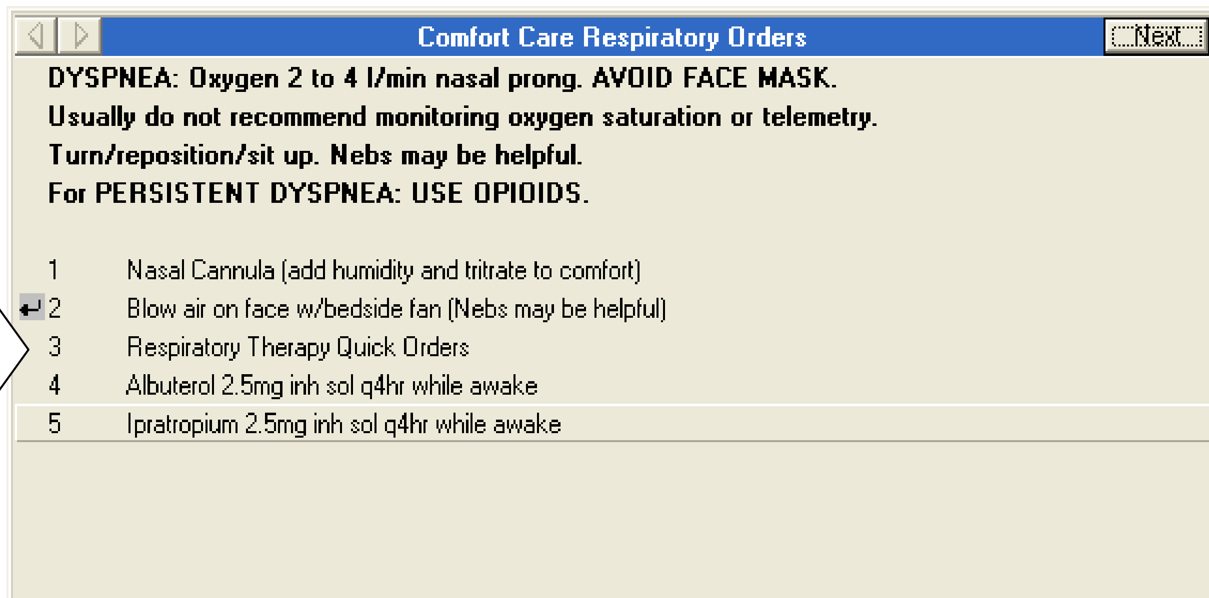
Section 8: IV Considerations (IV and Subcutaneous therapy)

Parenteral hydration may play a role in patient comfort at life's end. However, volume overload is a common iatrogenic problem in the inpatient setting at end of life. In addition, maintaining an IV site often causes pain, increases risk of infection and promotes the use of restraints. The subcutaneous line is a low burden option for parenteral access in almost all patients and can be used for parenteral access for medications, and in some clinical situations, the provision of fluids.



Section 9: Respiratory Orders

Oxygen therapy is a potent symbol of medical care. Face masks often are uncomfortable and burdensome, making patients feel more claustrophobic and dyspnic. The orders in this section focus on patient comfort of the patient as the primary goal and correction of hypoxia as a secondary concern. For most patients at end of life, correction of hypoxia will not be a feasible goal, but symptom control will.



This is an example of a component submenu. In this case, it is for the standard quick orders for respiratory therapy, but it can be a submenu to any quick order set a hospital may construct.

Respiratory Therapy Quick Orders Next

1	Oxygen Mask @ (FIO2)		**RESP THERAPY MEDS:**
2	Oxygen Nasal Cannula @ (Rate)		
3	Ventilator & (Mode)	30	Racemic Epinephrine/NS NOW
4	Incentive Spirometry	31	Racemic Epinephrine/NS Q30min X3
5	Pulse Oximetry (@ Rate)	32	Atrovent 0.5mg/NS Q2hr NEB
		33	Atrovent 0.5mg/NS Q4hr NEB
6	Suction	34	Atrovent 0.5mg/NS QID NEB
7	Turn/Cough/Deep Breathe (TCDB)	35	Albuterol 2.5mg/NS NEB Now
8	Sputum Induction	36	Albuterol 2.5mg/NS Q2hr NEB
9	Trach/Laryngectomy Care	37	Albuterol 2.5mg/NS Q4hr NEB
10	Chest Percussion/Postural Drainage (CPPD)	38	Albuterol 2.5mg/NS QID NEB
		39	Ventilator Bronchodilator Protocol
11	Vibro-percussion		
12	Request fan for pt bedside (Nebs maybe helpful)	99	Other Respiratory Therapy Orders (Free Text - not for medications)
20	Home O2 Evaluation		

Section 10: Pain & Dyspnea (Opioids)

Opioids are a key medication for pain and dyspnea; however, these medications frequently are under-utilized in the inpatient setting at end of life. The orders in this section are designed to encourage frequent symptoms assessment. They employ a scheduled "offer - may refuse" approach which increases the opportunity for patients to request and receive treatment and raises provider comfort with ordering and administering pain medication.

Comfort Care Opioid Orders   Next

PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effective.
Calculate morphine equivalents used in recent past adjust as needed.
SL q2hr offer patient may refuse.
PO meds offer longer duration of action then IV/subQ.
Morphine PO to IV equivalent is 3:1.

1 Morphine 5mg SL Q2hr
2 Morphine 5mg PO Q2hr
3 Morphine 2mg SQ Q2hr
4 Morphine 1mg IV PCA Pump per Protocol
5 Morphine 500mg/NS 50ml SQ Infusion
6 Oxycodone

CONSTIPATION: Initiate if on opioids or no BM x 2 days.

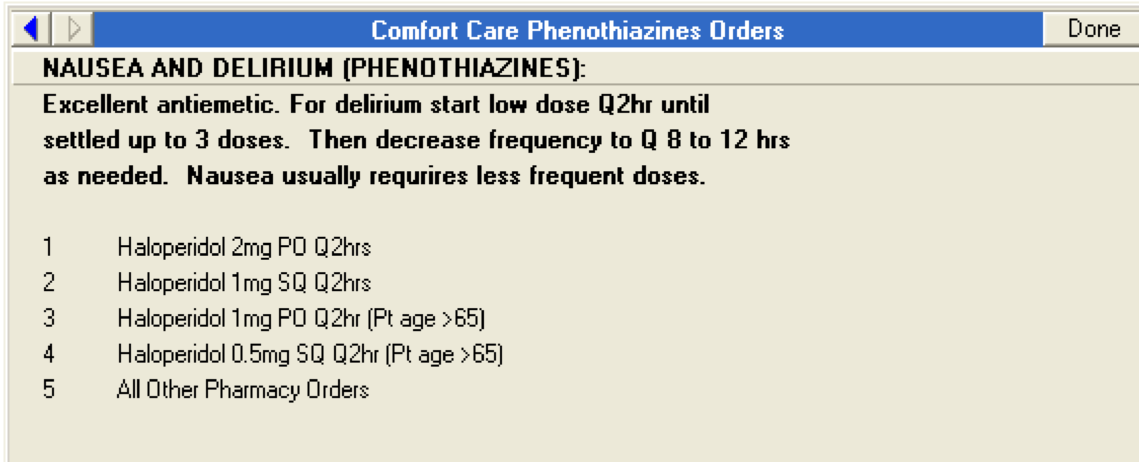
7 Please check for impaction
8 Bisacodyl 5mg PO BID
9 Sennosides 17.2mg PO BID (may crush)
10 Docusate 250mg PO BID
11 MOM 30ml PO DAILY PRN constipation
12 Lactulose 30gm/45ml DAILY
13 Bisacodyl SUPP 10MG PR DAILY PRN
14 FLeets enema PR DAILY PRN

PAIN DYSPNEA ANOREXIA ASTHENIA AND DEPRESSION: (Corticosteroid).
Dexamethasone has less mineral corticoid effect than Prednisone.
AM dosing prefered due to insomnia.
Dexamethasone 1mg is equivalent to Prednisone 6mg.

15 Dexamethasone 4 to 8 mg PO BID with meals
16 Dexamethasone 4 to 8 mg SQ BID (subq not compatible with hydromophone)

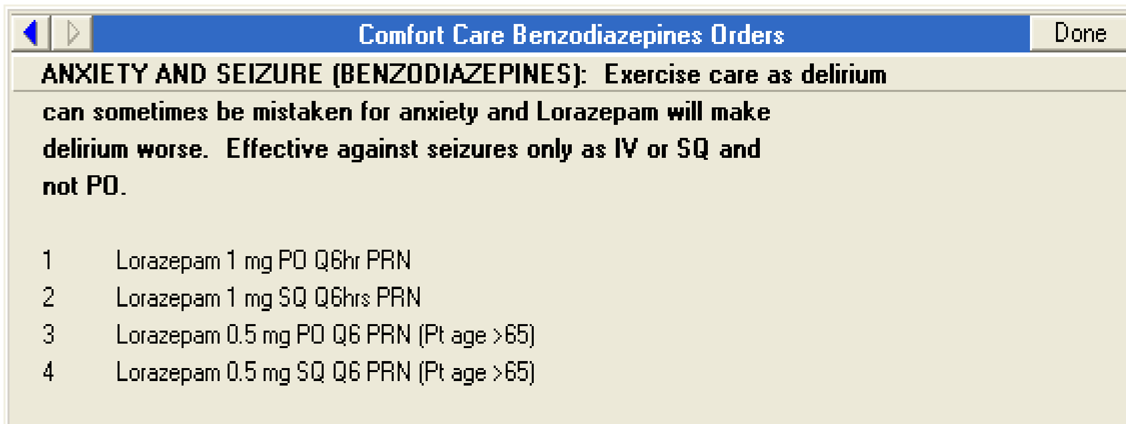
Section 11: Nausea & Delirium (Phenothiazines)

Haloperidol is both an effective anti-emetic and the mainstay of treatment for delirium at end of life. Addressing multiple symptoms with the same medication helps simplify symptom management at end of life.



Section 12: Anxiety & Seizures (Benzodiazepines)

Lorazepam is an effective medication for anxiety, which when given parenterally, is an effective anti-convulsant. Warnings about the potential of lorazepam to complicate treatment for delirium are imbedded in each order.



Section 13: Pain Dyspnea, Anorexia, Asthenia & Depression: (Corticosteroid)

Dexamethasone is an effective adjuvant for many patients. It is easier to convert from oral to parenteral routes when the same medication and dosages are used with both routes.

Comfort Care Corticosteroid Orders — Done

PAIN DYSPNEA ANOREXIA ASTHENIA AND DEPRESSION: (Corticosteroid).

Dexamethasone has less mineral corticoid effect than Prednisone.

AM dosing prefered due to insomnia.

Dexamethasone 1mg is equivalent to Prednisone 6mg.

10 Dexamethasone 4 to 8 mg PO BID with meals

11 Dexamethasone 4 to 8 mg SQ BID (subq not compatible with hydromophone)

Section 14: Constipation

Constipation is a common symptom at end of life. The constipation orders occur earlier in the opioid order section to encourage ordering a bowel regiment at the time the pain medication is ordered. In this section, constipation orders facilitate timely symptom identification and modification in the laxative therapy plan.

Comfort Care Constipation Orders — Done

CONSTIPATION: Initiate if on opioids or no BM x 2 days.

1 Please check for impaction

2 Bisacodyl 5mg PO BID

3 Sennosides 17.2mg PO DAILY (may crush)

4 Docusate 250mg PO BID

5 MOM 30ml PO DAILY PRN constipation

6 Lactulose 30gm/45ml DAILY

7 Bisacodyl SUPP 10MG PR DAILY PRN

8 FLeets enema PR DAILY PRN

Section 15: Death Rattle Orders

Loud, congested, and moist sounding respirations are a common symptom at the end of life. These death rattles are distressing to the family and staff.

Comfort Care Death Rattle Orders — Done

DEATH RATTLE: Keep back of throat dry by turning head to side.
Stop IVF or tube feeding.

1 Scopolamine patch behind ear Q 3 days
2 Atropine drops in back of throat Q4hr PRN
3 Glycopyrrolate 0.2/ml IV Q6hr
4 Glycopyrrolate 0.2/ml SUBQ Q6hr
5 Yankauer suction to bedside. Avoid deep suctioning
6 Cleanse mouth with Spongettes Q4hrs. Instruct family how to use.

Section 16: Additional Comfort Medications

While some patients may not need any of these adjuvant medications for specific problems at the end of life, others would benefit from many of the options.

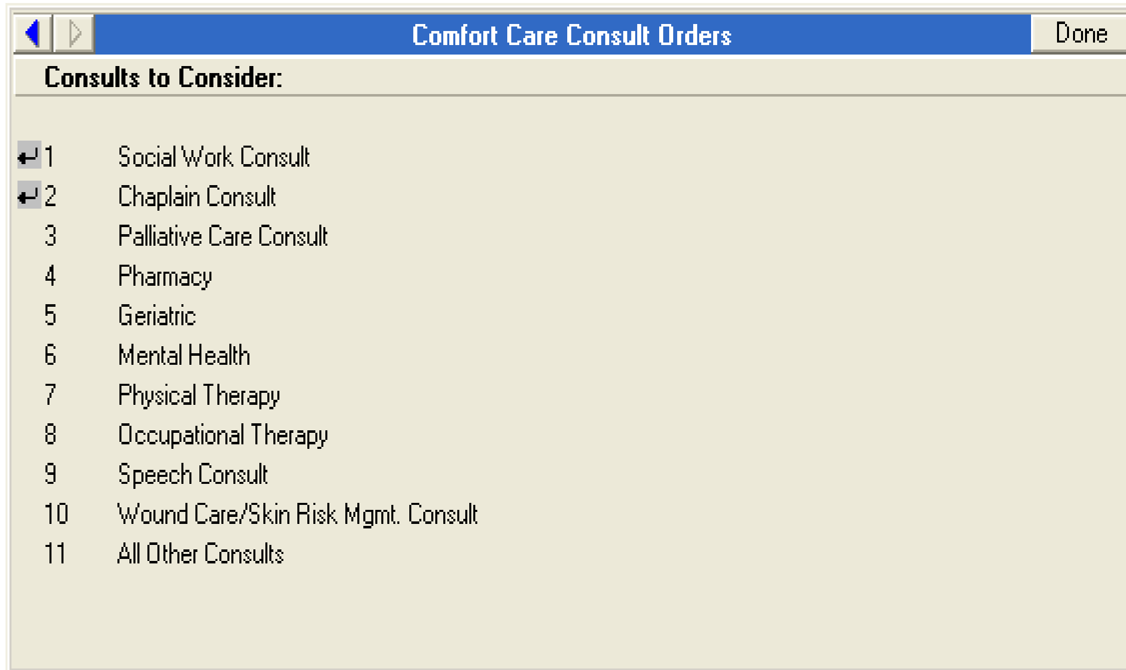
Comfort Care Additional Comfort Orders — Done

Please schedule medication if symptoms are continuous.

Fever:
1 Acetaminophen tab 650mg po q 4hr prn
2 Acetaminophen supp 650mg pr q 4hr prn
Insomnia:
3 Trazodone 25mg po qhs prn
Dry eyes:
4 Methylcellulose 0.4% opth sol 2 gtts each eye q6hr
5 Lacri Lube opth oint thin ribbon of Lacri Lube both eyes 6qhr
Sore mouth:
6 Mylanta benedryl lidocaine visc susp 30cc po ac prn
7 Cetylpyridinium mouthwash 1 rinse of 0.05% topical qid prn
Thrush:
8 Nystatin 100000UT/ml 5ml po qid x 7d
Sore throat:
9 Phenol spray 1.4% 2puffs of 1.4% qid
Cough:
10 Guaifenesin 100mg/5ml po q6hr
Hiccoughs:
11 Baclofen 10mg po tid prn
12 Chlorpromazine 25mg po q6hr prn
Dyspepsia:
13 Maalox plus extr str 30ml po q6hr prn
14 Ranitidine 150mg po bid
15 Omeprazole 20mg po qd
Diarrhea:
Call MD for Lomotil & C.Diff orders.
16 Pepto Bismol 262mg qid prn
Dysuria:
17 Phenazopyridine 100mg po tid x 2d

Section 17: Consults

This section prompts participation of the core members of the Palliative Care team and the providers in the specialty services of the specific medical center.



Comfort Care Order Set

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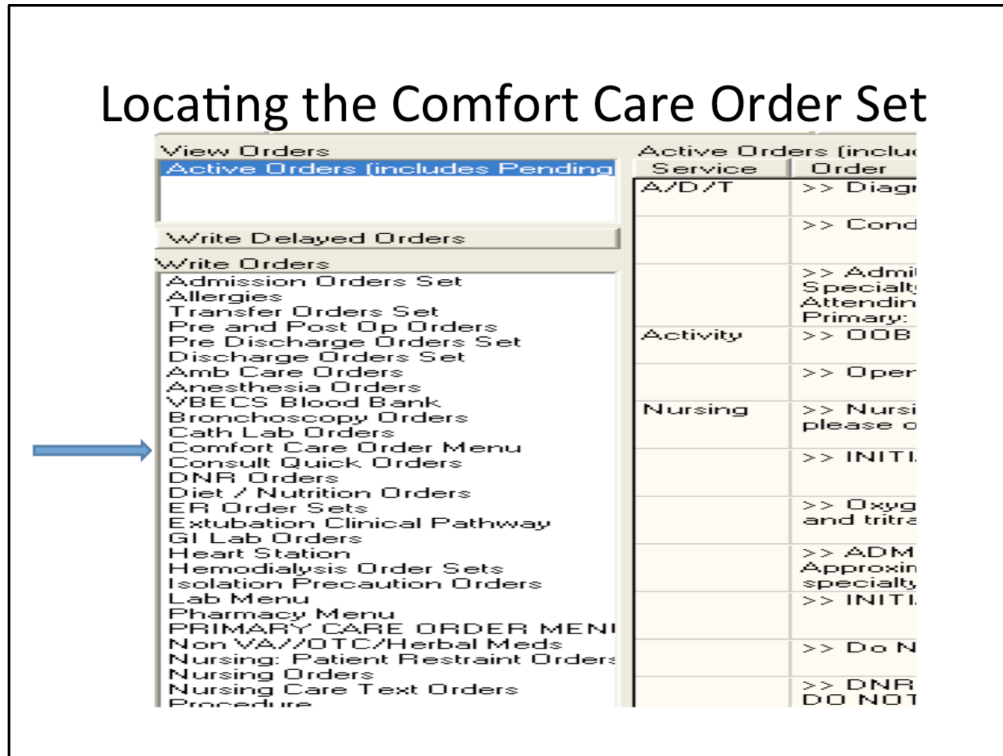


The Comfort Care Order Set should be placed in one or more locations so that it can be used readily. Most facilities place it in the section “Write Orders” for use by all providers who have the authority to write orders.

From this location you can open the CCOS and use orders to start symptom control for a patient that will continue to be cared for on that unit.

You may also want to use the CCOS to write delayed orders for a patient that will be transferred to a new unit in the VAMC or is being admitted to the VAMC.

If you have Palliative/Hospice Beds, orders can be copied into delayed orders and the option to change bed section to TS 96 in the CLC or to 1F for Hospice in Acute Care in the acute care section may be chosen.

Open the CCOS in Active Orders or Delayed Orders.

At this point, the provider may choose to open the CCOS and select orders that are needed by the patient.

A provider can write orders for immediate use and, at the same time, write a complete admission order set for the patient in the delayed order set that would be used if the patient is being moved to a different location (such as transfer out for the ICU to a CLC/ Hospice in Acute Care Bed).

A provider could also use the Delayed Order set if changing the bed section, but not changing geographic location.

The next slide will demonstrate the Delayed Order Writing Option.

Writing Delayed Transfer Order

Use Transfer: if inpatient will move from one ward o

Release new orders immediately

Delay release of new order(s) until

Event Delay List:

Transfer to Blind Rehab
Transfer to Cardiovascular Surgery
Transfer to E.N.T.
Transfer to General Medicine
Transfer to General Surgery
Transfer to Gynecology
Transfer to Head & Neck Surgery
Transfer to Hospice for Acute Care
Transfer to Medical ICU/CCU
Transfer to Neurology
Transfer to Neurosurgery
Transfer to Ophthalmology
Transfer to Oral Surgery
Transfer to Orthopedic Surgery
Transfer to Plastic Surgery
Transfer to SICU/CVICU
Transfer to Thoracic Surgery
Transfer to Urology (GU)
Transfer to Vascular

Admit to Blind Rehab
Admit to Cardiac Surgery
Admit to Cardiovascular Surgery
Admit to E.N.T.
Admit to General Medicine
Admit to General Surgery
Admit to Gynecology
Admit to Head & Neck Surgery
Admit to Hospice for Acute Care
Admit to Medical I.C.U./C.C.U.
Admit to Neurology
Admit to Neurosurgery
Admit to Ophthalmology

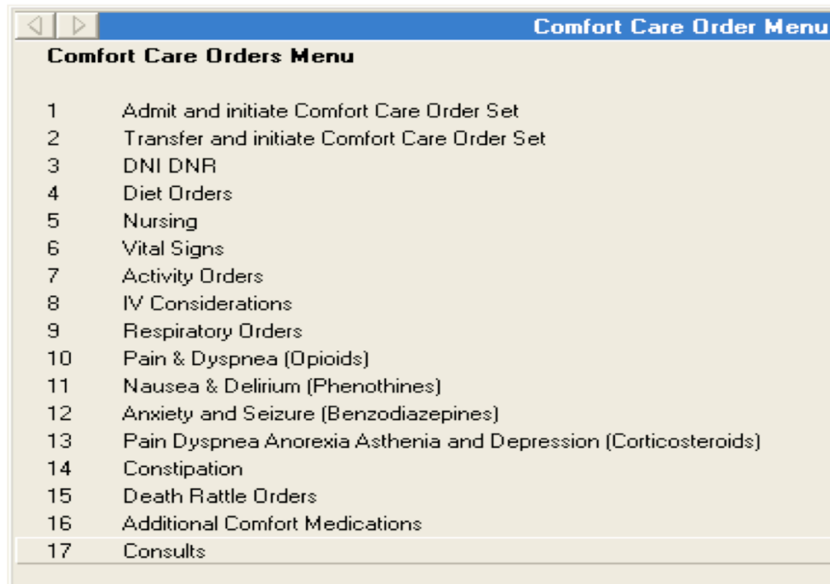
Opening Delayed Orders

Choose to have patient admitted to VAMC under the appropriate bed section, such as TS 96 or 1F.

If the patient has already been admitted to the VAMC and you want to change the bed section, you can use the “Transfer to” option at the top of this window.

Note that you may be changing the bed section designation, but not changing the location of the bed. In that case you **do** have to enter new orders, and using the Delayed Orders is the best option to do this without the patient having a break in orders that could cause poor symptom control .

Comfort Care Order Set

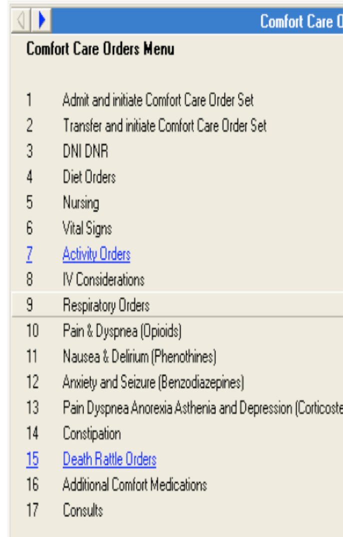


This is the appearance of the Comfort Care Order Set when you select the option in the "Write Orders" tab. At this point, you could start at the top and work your way through the list. It is recommended that a provider work through all of the sections a few times to become familiar with the CCOS. After using the CCOS for 3-5 times, a provider can write a complete set of orders in about 5 minutes.

It is encouraged to go through all of the parts of the order sets, so that some important aspect of care is not inadvertently overlooked. Also, it is a good practice to place an order for medication for pain, for delirium, or for other symptoms preemptively, so that if the patient develops symptoms later during the night, the staff is able to respond quickly.

On other occasions, you may want to select only a few options for a specific problem, such as management of secretions and go to that section of the order set directly.

If a Section of the CCOS has been opened it becomes Blue



Click on done to exit
Click on blue arrow (top left) to return to previous menu
Click on IV Considerations below to continue in the order set
IV Considerations

This prompts you to remember which sections you have already completed. If you change your mind and want to go back into that section to modify your orders, you can do that without having to close and reopen the CCOS.

Below is a navigation tool that is placed at the end of each section. Note that the "Done" button intuitively seems like the button to use to continue, but it actually closes the order set. This set of instructions and the construction of the order set allows the clinician to go back to the option page or progress to the next option in the list.

Click on done to exit
Click on blue arrow (top left) to return to previous menu
Click on IV Considerations below to continue in the order set
IV Considerations

Using the Comfort Care Order Set

Admit and Initiate Comfort Care Order Set

Order: ADMIT TO AND INITIATE COMFOF

Admit patient when(date/time)? Jul 30,2010@12:00

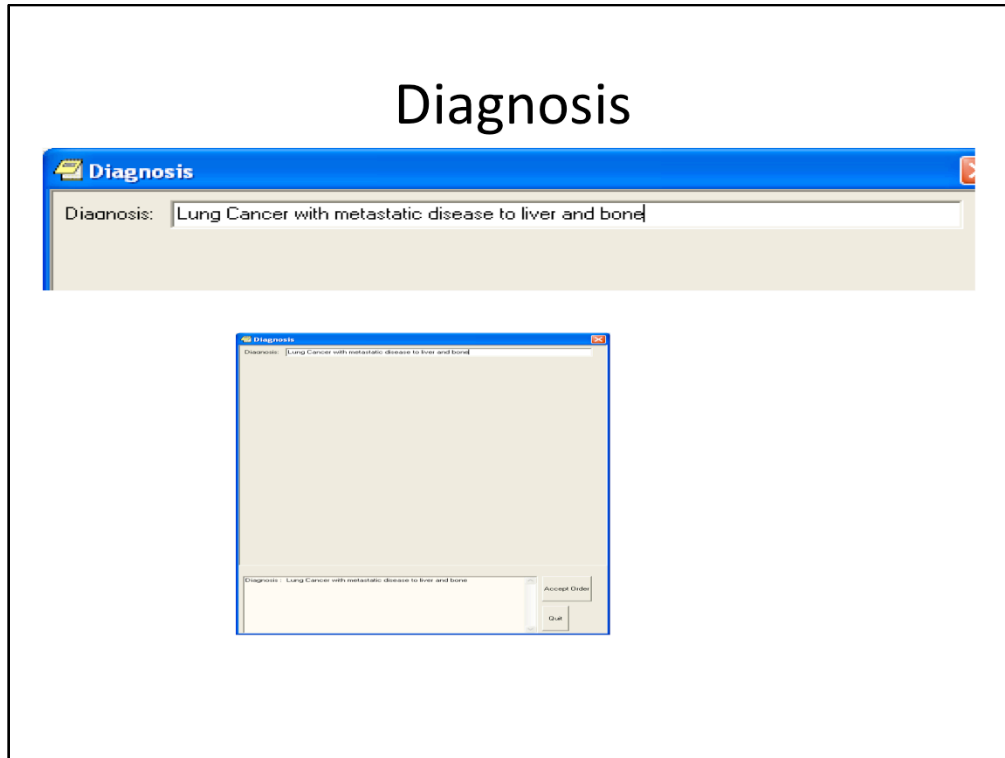
What treating specialty/team:

Start: HOSPICE FOR ACUTE CARE
GENERAL MEDICINE

If you are admitting a patient to the VAMC and wish to use the CCOS, you select the “Admit and Initiate” option. The initiation of CCOS is a marker to the staff in the hospital that the patient has special needs. You could conceive of this as a marker such as “Falls Risk” or “Wandering Risk.”

The provider is prompted to select the date and time.

The provider is prompted to select a bed section. You may want to include TS 96 if you have a CLC and Hospice/Palliative Care. Hospice in Acute Care is also an option (1F). In the Birmingham VAMC example we have General Medicine as an option, because we have a mixed unit, with some patients in an Acute Care for the Elderly Track within the General Medicine Bed section.



Diagnosis

There is an administrative requirement to have a diagnosis for the admission. This prompts the provider to fulfill this requirement.

Condition

Patient's Condition

Order: CONDITION

Enter condition:

Start:

Stop:

CRITICAL
FAIR
GOOD
POOR
SERIOUSLY ILL
GRAVE

Patient's Condition
Order: CONDITION
Enter condition:
Start:
Stop:
CRITICAL
FAIR
GOOD
POOR
SERIOUSLY ILL
GRAVE

CONDITION :

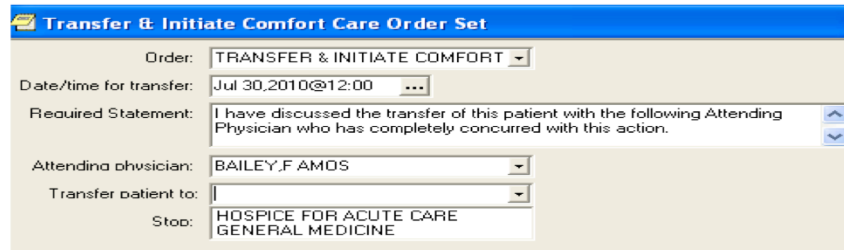
Accept Order

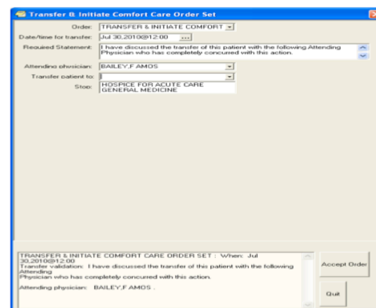
Quit

Condition

Condition is also an administrative requirement to be declared at admission. This option has a pull down menu and point-and-click option. A facility that is choosing to use the CCOS should populate this with the conditions that the facility uses by policy.

Transfer Option

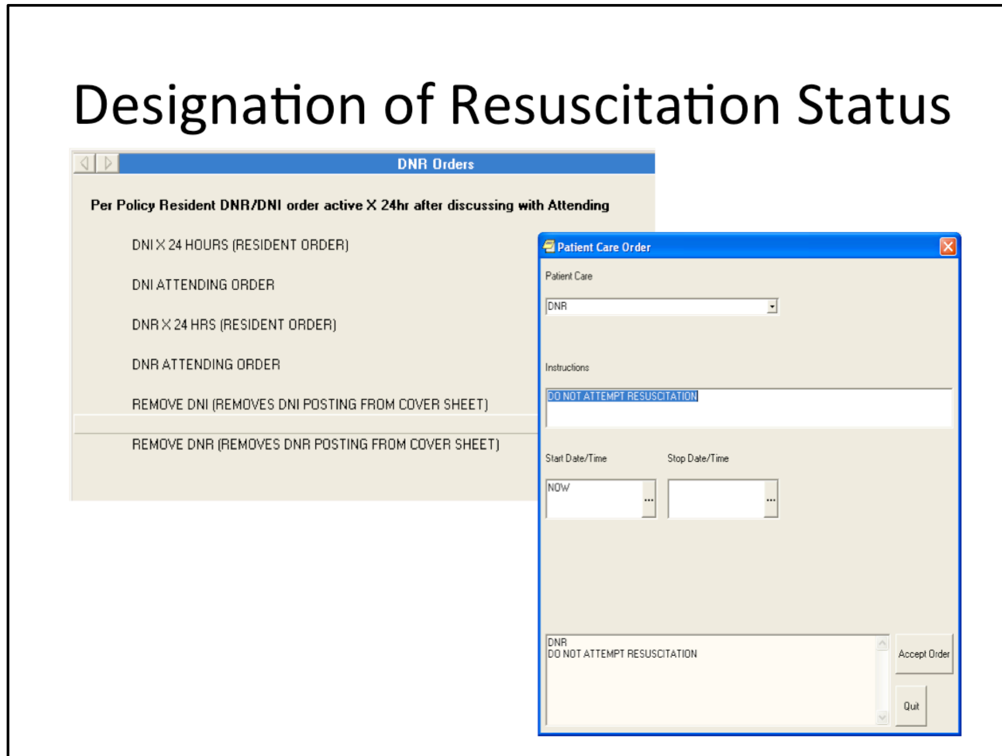




Transfer Option

This is used when transferring the patient from one location or service to another after admission. It does require selecting the attending and in this slide gives you an option to select the appropriate bed section .

This option is followed by the “Diagnosis” and “Condition” prompts as noted on the previous example for an admission.



Designation of Resuscitation Status

It is not mandatory that a patient must have a DNAR order to utilize and benefit from using the Comfort Care Order Set . However, if use of the CCOS is being considered, then a discussion regarding resuscitation status is almost always appropriate. This prompt allows you to more easily document that communication.

Additional Notes

The Comfort Care Order Set usually uses CPRS orders already in use in your institution. So this section may appear different depending on your hospital policy. This demonstrates using the DNAR (Do Not Attempt Resuscitation), which is the preferred nomenclature in the VHA.

The Office of Ethics is developing a Template Note for Documentation of Preferences for Life Sustaining Therapy that will become a POLST Document and Orders. The timeline for the launch of this plan is not determined. However, this can be substituted here if this process is adopted at your VAMC.

In addition, the position of this item can vary and some centers have chosen to place it at the end of the CCOS. The exact sequence of items can be varied but it is recommended that all items be included.

Diet Orders

Comfort Care Diet Orders

DIET: Patient may improve and desire to taste food.

Order full liquid instead of clear liquid. More palatable.

Easier to swallow. Less likely to cause aspiration. Advance as tolerated.

1 Diet / Nutrition Orders

2 Full Liquid Diet

↵3 May have food brought in by family

↵4 Allow patient to sit up for meals. Assist to eat.

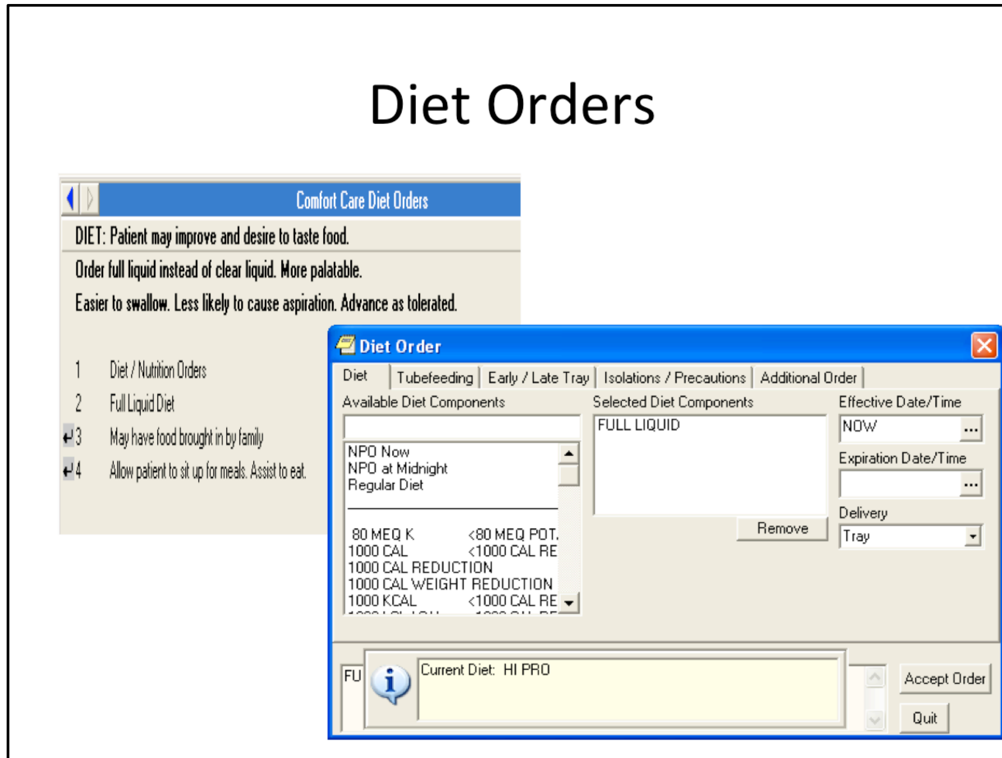
Diet Orders

This slide illustrates the decision support aspect of the Comfort Care Order Set.
The bolded black text is an educational note to the providers.

This order section reflects that comfort and pleasure eating is often appropriate. Most patients on home hospice are allowed to eat or drink small amounts as desired. These same patients are often designated as NPO in the hospital, which is frequently not necessary and causes distress to patient and family. The default diet that is recommended is the Full Liquid Diet, because this is usually safer to swallow and is much more palatable with ice cream and other soft foods as an option.

If the provider wishes to order a standard diet, the option is available.

The following orders are recommended: "May have food brought in by family" and "Allow patient to sit up to eat. Assist with meals." Patients are not supposed to eat food other than that provided by the facility, unless there is an order. Families may need prompting and assistance to learn to help the patient sip or eat safely if they desire food.



Diet Orders

This slide illustrates the default option that may be selected by clicking the “Accept Order “ button.

Diet Orders

Comfort Care Diet Orders

DIET: Patient may improve and desire to taste food.

Order full liquid instead of clear liquid. More palatable.

Easier to swallow. Less likely to cause aspiration. Advance as tolerated.

1	Diet / Nutrition Orders
2	Full Liquid Diet
3	May have food brought in by family
4	Allow patient to sit up for meals. Assist to eat.

Diet / Nutrition Orders

RG	Order a Regular Diet	TF	Order a TUBEFEEDING...
1	Order 1800 ADA Diet	20	Order Early or Late Food Tray
2	Order 1800 ADA Diet w/HS Snack		
3	Order 2000 ADA Diet	30	NPO Order (specify date/time)
4	Order CHEMO Diet	31	NPO at MIDNIGHT Tonight
5	Order CLEAR LIQUID Diet	32	NPO NOW Order
6	Order DENTAL Diet	33	NPO Except Ice Chips
7	Order FULL LIQUID Diet		
8	Order MODIFIED CLEAR LIQ Diet		
9	Order PRUDENT Diet		
10	Order PUREE Diet		
11	Order 2Gm NA Diet		
12	Order 4Gm NA Diet		
		99	Build your own Diet Order

Diet Orders

This slide illustrates that if the provider needs to order a diet other than the full liquid default diet, they can choose from all the options offered at the specific facility offers.

Sample Nursing Orders

Comfort Care Nursing Orders

NURSING:

TIPS FOR COMFORT/SAFETY:
Comforting measures. Reposition. Massage. Speak to patient.
Soft music. Avoid sensory overload (TV).

1 Please weigh on admission to Safe Harbor and weekly on Mondays thereafter
2 For CHF please weigh daily
3 May discontinue lab tests and daily wts and SCD's and subq Heparin and discontinue telemetry
4 RN may change form of medicine and route of administration. No IM meds
5 Keep hearing aid and dentures and glasses on pt.
6 Audiology consult:obtain amplifier for HOH patient
7 If actively dying please turn only for comfort
8 Please designate the patient HOSPICE FOR ACUTE CARE

ACTIVITY: AVOID RESTRAINTS. Patient may need one on one sitter.

Begin environment modifications:

9 OOB to chair BID and preferably outside
10 Open curtain during day.
11 Decrease unnecessary noise (turn off TV)
12 Redirect ~ Reposition ~ Speak quietly
13 Provide nightlight when sleeping.
14 Please allow family to stay with patient in room

ASSISTING FAMILY:
Advise family about alerting their family members as to gravity of pt status. Arrange family visits of military relatives by contacting Red Cross and of incarcerated relatives by contacting warden. SW may assist.

15 Please give family "Preparing For Your Loved One's Loss"

Nursing Orders

This section allows for a quick selection of orders for patient comfort. In addition, you can use the offered orders and a decision support tool to plan environmental modifications for specific issues, such as care of the actively dying patient or for delirium.

This page is broken up into two parts, so that the content will be easily understood.

Nursing Care Orders

Comfort Care Nursing Orders

NURSING:

TIPS FOR COMFORT/SAFETY:
Comforting measures. Reposition. Massage. Speak to patient.
Soft music. Avoid sensory overload (TV).

1 Please weigh on admission to Safe Harbor and weekly on Mondays thereafter
2 For CHF please weigh daily
3 May discontinue lab tests and daily wts and SCD's and subq Heparin and discontinue telemetry
4 RN may change form of medicine and route of administration. No IM meds
5 Keep hearing aid and dentures and glasses on pt.
6 Audiology consult:obtain amplifier for HOH patient
7 If actively dying please turn only for comfort
8 Please designate the patient HOSPICE FOR ACUTE CARE

ACTIVITY: AVOID RESTRAINTS. Patient may need one on one sitter.

Begin environment modifications:

Part 1 Tips For Comfort and Safety

This is a list of potential orders to reduce unneeded interventions and for patient comfort. Examples include not using IM injections, changing routes of medications, discontinuing telemetry, SCD's, and subcutaneous heparin, as well orders for turning that are oriented to comfort.

If there is an arrow for this, then the order can go in directly to the order sheet. If not, a dialogue box will appear that may require further information or customization.

Nursing Care Orders

ACTIVITY: AVOID RESTRAINTS. Patient may need one on one sitter.

Begin environment modifications:

↵ 9 OOB to chair BID and preferably outside
↵ 10 Open curtain during day.
↵ 11 Decrease unnecessary noise (turn off TV)
↵ 12 Redirect ~ Reposition ~ Speak quietly
↵ 13 Provide nightlight when sleeping.
↵ 14 Please allow family to stay with patient in room

ASSISTING FAMILY:
Advise family about alerting their family members as to gravity of pt status. Arrange family visits of military relatives by contacting Red Cross and of incarcerated relatives by contacting warden. SW may assist.

↵ 15 Please give family "Preparing For Your Loved One's Loss"

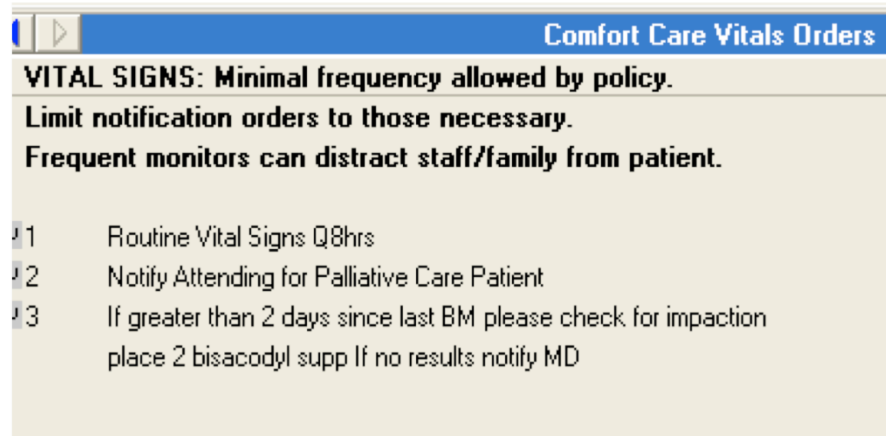
Part 2
Tips For Comfort and Safety
Avoid Restraints

The following orders (9-14) are all part of the environmental modification for management of delirium and agitation.

"Assisting Family" is decision support to remind providers to assess family needs and the potential need to refer to other members of the IDT, such as Social Work or Pastoral Care, for assistance.

"Preparing for Your Loved One's Loss" is an educational pamphlet that describes the dying process for family members. It can be given to families and the clinicians can review the content with them to help them cope with sitting in vigil with a patient.

Vital Signs



Vital Signs

Monitoring often increases in intensity at the end of life in hospital settings. This can be uncomfortable for the patient and distracts both family and staff from symptom needs.

Vital signs may be placed at minimum for unit policy, such as once a shift in the Acute Care and once a day in CLC. It may be appropriate to stop doing vital signs particularly in the actively dying patient. However, taking vital signs is a potent symbol of medical care. Patients and families may misunderstand not taking vital signs as not caring or even abandonment. If this issue is discussed and a decision is made to stop doing vital signs, then this could be ordered instead.

See notification on the next page

Also, there is a reminder to assess constipation. Daily review of bowel regimen effectiveness by noting of BM in last 24-48 hours helps reduce painful constipation or obstipation.

Notifications

Notify MD

Order: Notify patient's MD or House Officer if:
Respiratory Status: Labored breathing not relieved with medication.
Agitation: Agitation/Delirium not relieved with medication.
Pain: Pain not controlled with medication.
Family Present: Family present and need to speak with physician.
Start Date: now
Stop Date: T+21

Order: Notify patient's MD or House Officer if:
Respiratory Status: Labored breathing not relieved with medication.
Agitation/Delirium: Agitation/Delirium not relieved with medication.
Pain: Pain not controlled with medication. Family Present: Family present and need to speak with physician.

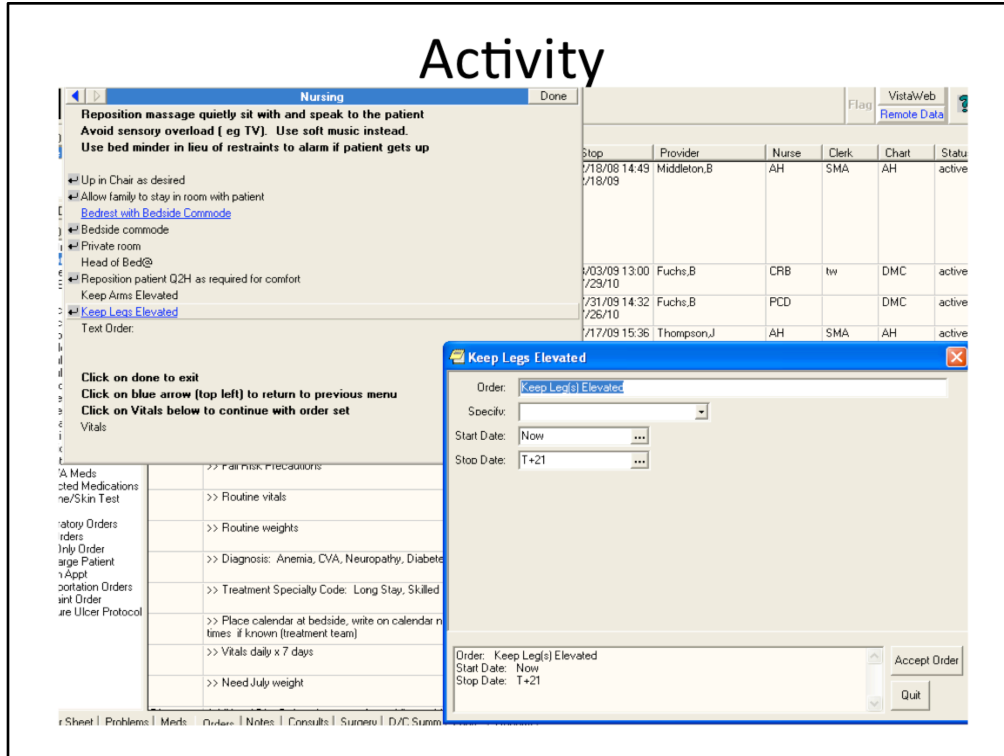
Accept Order
Quit

The notifications in this section are based on patient symptom burden, as opposed to a set of vital sign reports.

Examples
Pain not controlled with medications
Labored breathing not controlled with medications
Delirium/Agitation not relieved with medication
Family present and need to speak with clinician

These notifications reflect the comfort care order plan and the need to modify the treatment if it is not effective.

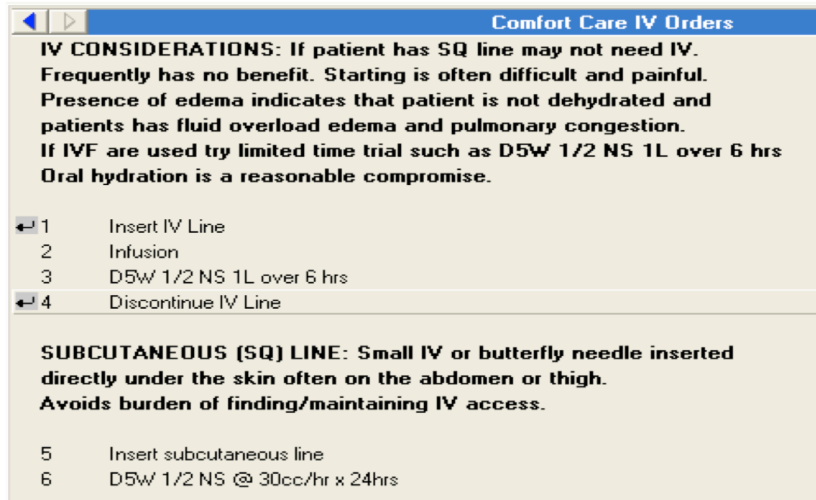
In the next sections, treatments for each of the symptom clusters are presented to the clinician.



Activity

This is an example of another option for an activity page that could prompt clinicians to consider orders that allow patients to get into a position that is comfortable and least restrictive. Patients at end of life have often have restrictive orders, such as strict bed rest, that are not consistent with goals of care and usually are not necessary or even helpful for patients.

IV Considerations

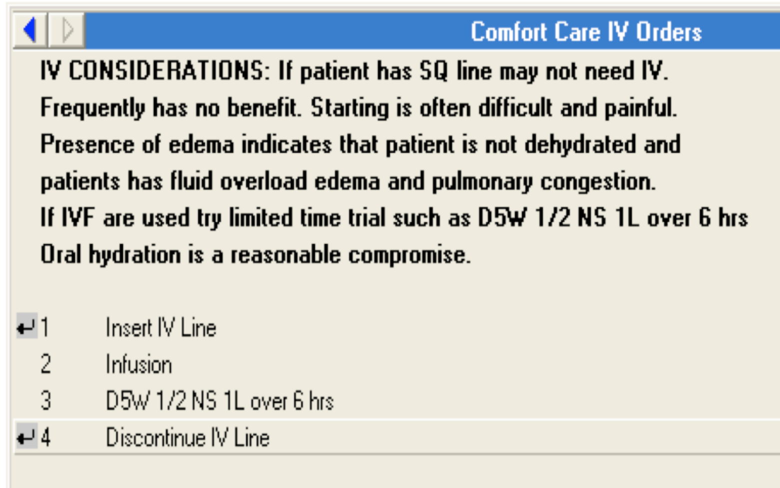


Patients on home hospice programs do not commonly receive intravenous (IV) fluids. However, in the hospital, IV fluids are a potent symbol of care and represent that providers are “doing something.” IV fluids at end of life in the hospital can be beneficial. For some patients, hydration with IV fluids may be helpful to manage a reversible delirium or bridge declined oral intake until a time of recovery. In addition, there are some medications, such as antibiotics, or other treatments, such as blood transfusion, that may be helpful in palliation of specific symptoms.

However, IV lines can also be burdensome for patients at end of life. IV access is often difficult to maintain, which leads to patient discomfort when multiple attempts are made to start an IV. There is also significant risk of line-associated infection. In many patients, IV fluids contribute to edema and fluid overload, which is distressing in itself. In addition, patients on maintenance IV fluids are tethered by this line and may be restrained to protect the line.

Most medications for comfort can be given through a subcutaneous (SQ) line, which is easy to place and maintain, is not painful, and has low risk of infection. Medications that can be administered subcutaneously include opioids, lorazepam, haloperidol, and dexamethasone. The medications are often given intermittently, but the subcutaneous line can also be used for continuous infusion of opioids.

IV Fluids



See details of the IV decision support education.

Options
Insert IV if IVF or IV medications would be an appropriate palliative treatment.

Default IVF is one 1000ML of D51/2 NS over 6 hours. This illustrates the idea of ordering fluids as needed and also of using intermittent fluids. This could be customized , however most patients could tolerate this rate for 6 hours if they truly needed fluids. The patient is then liberated from the IV line, so that it does not interfere with comfort or position, and avoids struggling to prevent the line from being dislodged .

If a different fluid is preferred, one can choose “Infusion” to go to CPRS chooses.

Consider a “Remove IV” order. Frequently, the patient has an IV and it may not be needed. It should be removed, because there is a risk of infection. Also, in many facilities, IVs are automatically replaced on a 3-day interval, which is a burdensome procedure for patients .

Subcutaneous Line

SUBCUTANEOUS (SQ) LINE: Small IV or butterfly needle inserted directly under the skin often on the abdomen or thigh.
Avoids burden of finding/maintaining IV access.

5 Insert subcutaneous line
6 D5W 1/2 NS @ 30cc/hr x 24hrs

Subcutaneous Line

This section provides decision support to use subcutaneous line and therapy.

Frequently the subcutaneous line is placed and is used for intermittent injection of opioids or other comfort medications. There are significant pharmacological advantages to SQ opioids, because the duration of the opioid effect is longer.

The subcutaneous line could also be used for continuous infusion via a PCA pump. These pumps are usually for morphine or hydromorphone infusion, but could be used in select patients for benzodiazepines.

In some cases, it may be appropriate to place more than one SQ line, when a continuous infusion is needed for one medication and a second line is needed for an intermittently administered medication.

Hyperdermoclysis is the infusion of fluid with a SQ line. See next page for more details.

Hyperdermoclysis

Infusion Order

Solutions | Additives

0.225% NACL <SODIUM C
0.225% SODIUM CHLORIDE
0.45% NACL/5% DEXTROSE
0.45%NS <SODIUM C
0.9% NACL <SODIUM C
0.9% NACL IRRIGATION
0.9% SODIUM CHLORIDE
0.9% SODIUM CHLORIDE IRRIG.
1/2 NS <SODIUM C
1/2NS <SODIUM C
10% DEXTROSE <DEXTROS

Solution/Additive* | Volume/Strength*
DEXTROSE 5%/SODIUM CHLORIDE 0.45% INJ,SOLN | 500 ML

Remove

Comments
Infuse 30cc/hr x 24 hrs (continuous), SQ line fluid trial order for palliative care patient

Route* (Expanded Med Route List): SUBCUTANEOUS
Type* (IV Type Help): Continuous
Schedule*
PRN
Infusion Rate (ml/hr)*: 50

Priority*: ROUTINE
Duration or Total Volume (Optional): 720 ml

* Indicates a Required Field

DEXTROSE 5%/SODIUM CHLORIDE 0.45% INJ,SOLN 500 ml SUBCUTANEOUS 50 ml/hr with total volume 720ml
Infuse 30cc/hr x 24 hrs (continuous), SQ line fluid trial order for

Accept Order
Quit

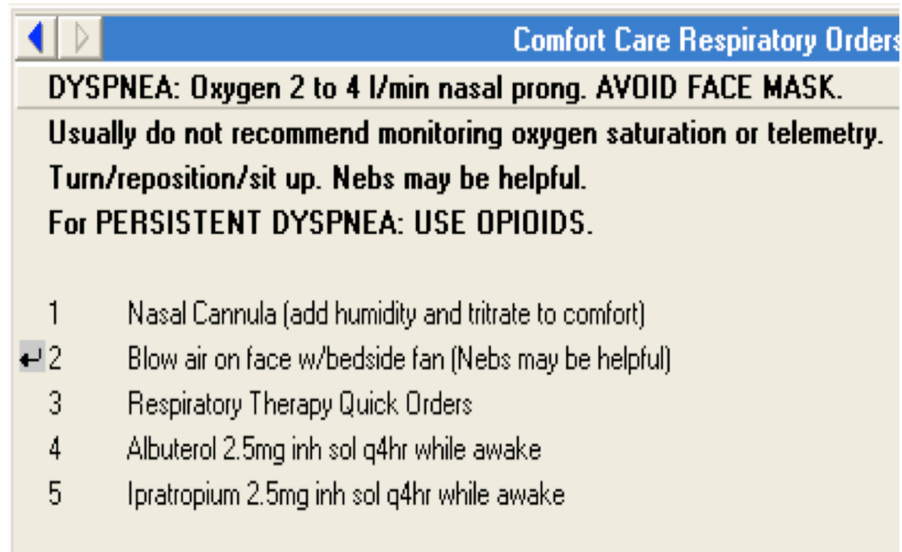
Hyperdermoclysis

Hyperdermoclysis is the infusion of parental fluids into the subcutaneous tissue. This process can take longer to get the fluids in, but can be effective and is often a much less invasive procedure than placing a central line or IV .

The default is for a lower 30cc or 50cc per hour infusion. As mentioned earlier, IV fluids are a potent symbol of care and caring. Some families, even after discussion and teaching, may feel uncomfortable with stopping IV fluids in patients who are clearly not benefiting or even in patients who may be having distress related to the ongoing fluids. In these rare cases, low flow rate hyperdemoclyis may meet the family's need for symbolic care and reduce the burden of the therapy on the patient.

However, hyperdermoclysis can be an effective rehydration strategy. The SQ line for hyperdermoclysis should be placed on the abdominal wall to give more space for fluid diffusion. If two lines are placed, one on each side of the abdomen, and a flow rate of 50ml each is used, a liter could be infused in 10 hours and up to 2 1/2 liters could be infused in a 24-hour period, which could significantly rehydrate a patient that might benefit from this.

This appendix also includes an example of policy and procedures for subcutaneous line placement and for subcutaneous medicine administration and hyperdermoclysis.



Respiratory Therapy

Oxygen may be an effective treatment for hypoxia and dyspnea. However, oxygen is also a potent symbol of medical care. In home hospice settings, oxygen via nasal prong and A/A nebulizer are commonly provided and seem to help relieve symptoms. Many patients wear the oxygen for part of the time, but also use environmental modifications, such as a fan or air conditioner to blow air on the face, sitting up and leaning forward, or pursed lip breathing, which are all techniques to allow for better expansion of lung, takes advantage of auto-peep and leads to reduction of dead space.

Patients in the hospital who have severe dyspnea/hypoxia may have much more invasive procedures, such as face mask, BiPAP, CPAP, or ultimately mechanical ventilation. This is often very appropriate, if aligned with patient goals of care and as a trial of treatment to bridge to time of recovery. However, for many patients at end of life in the hospital setting, these treatments are burdensome and not effective in relieving symptoms. On the other hand, the environmental modifications described above are often not utilized or not available and/or patients are prevented from modifying their personal environment for their comfort.

Oxygen Nasal Cannula

Oxygen Nasal Cannula at

Orderable Item: OXYGEN NASAL CANNULA

Specify flow rate (L/min): 2 L/m

Start: NOW

Stop: t+30

OXYGEN NASAL CANNULA at flow rate of 2 L/m , add humidity and titrate to comfort

Accept Order

Quit

Oxygen therapy is a potent symbol of medical treatment.

In addition, oxygen therapy may reduce dyspnea by correcting hypoxia. However ,in many patients at end of life correction of hypoxia is not necessarily feasible and is not closely correlated with dyspnea. This means that many patients who have dyspnea may not be hypoxic. Others have dyspnea even if hypoxia has been corrected. Oxygen therapy by nasal cannula may have a placebo effect. Also , there is some evidence indicating that air moving over the airways may relieve dyspnea as effectively as oxygen in some patients.

Many patients at end of life do not tolerate an oxygen mask, as it makes then feel smothered, even if it does reduce the hypoxia. If the mask or more intrusive oxygen therapy such as BiPAP or CPAP is a bridge to a time of recovery then a trial of treatment may be indicated.

The default order here is for Oxygen 2 l/m Nasal Cannula and to titrate to comfort. This is in line with how oxygen supplementation is used in home hospice and most patients at end of life find it most useful.

This is coupled with the order to have a fan at the bedside to blow air on the patient for comfort.

Albuterol Nebulization

Medication Order

ALBUTEROL 0.5% SOLN FOR INHAL UD SOLN,INHL

Change

Dosage | Complex | Route | Schedule (Day-Of-Week) | PRN

2.5MG 0.5% | INHALATION | Q4HR

Q1HR Q24HR Q2HR Q-2WEEKS Q30 MINS Q3D Q3HR Q-3WEEKS Q48HR Q4HR Q-4WEEKS Q5MIN Q6HR Q72HR Q8HR Q96H

Comments: WHILE AWAKE

Give additional dose now

Priority: ROUTINE

Admin Time: 0200-0600-1000-1400-1800-2200

Expected First Dose: TODAY (Aug 07, 10) at 14:00

DISP PER EACH (30/BOX)

ALBUTEROL 0.5% SOLN FOR INHAL UD SOLN,INHL 0.5%
2.5MG INHL Q4HR WHILE AWAKE

Accept Order

Quit

Albuterol and ipratropium nebulization are commonly provided to patients with respiratory distress. Many patients have some component of reactive airway disease, even if it is not the primary cause of there illness. Many patients also report subjective benefit from A/A nebulization, particularly if they are too weak to be able to effectively use the Metered Dose Inhaler. Therefore, the order set allows the provider to quickly order these treatments. Either one or the other or both may be ordered. Some patients may experience anxiety associated with the albuterol treatment.

The orders are set at a default of Q4 hours, but note that WHILE AWAKE so that if a patient is comfortable the nebulization could be skipped. Modifications can be made, such as ordering QID, so that sleep is not disrupted or the clinician could use the order twice to set up a QID routine and the second time to provide for a PRN option.

See the next slide for the ipratropium order.

Ipratropium Nebulization

Medication Order

IPRATROPIUM BR 0.02% INH SOLN UD SOLN,INHL | Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

IPRATROPIUM BR 0.02% INH SOLN UD SOLN,INHL | INHALATION | Q4HR | PRN

INHALATION

Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS
QHS PRN
QID
QID SS
QNOON
QPM
QPM (ANTI-DIABETIC)
QPM (EVENING-MEAL)
SA
STAT

Comments: IN 3ML NS. WHILE AWAKE

Give additional dose now

Priority: ROUTINE

Admin. Time: 0200-0600-1000-1400-1800-2200

Expected First Dose: TODAY (Aug 07, 10) at 14:00

IPRATROPIUM BR 0.02% INH SOLN UD SOLN,INHL
IPRATROPIUM BR 0.02% INH SOLN UD SOLN,INHL INHL Q4HR IN 3ML NS. WHILE AWAKE

Accept Order | Quit

See discussion of this option on the previous slide.

Respiratory Therapy Menu

Respiratory Therapy Quick Orders

1	Oxygen Mask @ (FIO2)		**RESP THERAPY MEDS:**
2	Oxygen Nasal Cannula @ (Rate)		
3	Ventilator & (Mode)	↵ 30	Racemic Epinephrine/NS NOW
4	Incentive Spirometry	↵ 31	Racemic Epinephrine/NS Q30min X3
5	Pulse Oximetry (@ Rate)	↵ 32	Atrovent 0.5mg/NS Q2hr NEB
		↵ 33	Atrovent 0.5mg/NS Q4hr NEB
6	Suction	34	Atrovent 0.5mg/NS QID NEB
7	Turn/Cough/Deep Breathe (TCDB)	↵ 35	Albuterol 2.5mg/NS NEB Now
8	Sputum Induction	↵ 36	Albuterol 2.5mg/NS Q2hr NEB
9	Trach/Laryngectomy Care	↵ 37	Albuterol 2.5mg/NS Q4hr NEB
10	Chest Percussion/Postural Drainage (CPPD)	38	Albuterol 2.5mg/NS QID NEB
		39	Ventilator Bronchodilator Protocol
11	Vibro-percussion		
↵ 12	Request fan for pt bedside (Nebs maybe helpful)	99	Other Respiratory Therapy Orders (Free Text - not for medications)
20	Home O2 Evaluation		

This is standard menu for respiratory therapy. Patients referred to hospice and palliative care programs may benefit from one or more of the additional options. For example, a significant number of patients have a change in goals of care after a prolonged period of Mechanical Ventilation that has led to the placement of a tracheotomy. In that case, tracheotomy care options are helpful in managing the care of a specific patient safely and comfortably.

Opioid for Pain and Dyspnea

Comfort Care Opioid Orders

PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effective.
Calculate morphine equivalents used in recent past adjust as needed.
SL q2hr offer patient may refuse.
PO meds offer longer duration of action then IV/subQ.
Morphine PO to IV equivalent is 3:1.

1 Morphine 5mg SL Q2hr
2 Morphine 5mg PO Q2hr
3 Morphine 2mg SQ Q2hr
4 Morphine 1mg IV PCA Pump per Protocol
5 Morphine 500mg/NS 50ml SQ Infusion
6 Oxycodone

CONSTIPATION: Initiate if on opioids or no BM x 2 days.

7 Please check for impaction
8 Bisacodyl 5mg PO BID
9 Sennosides 17.2mg PO BID (may crush)
10 Docusate 250mg PO BID
11 MOM 30ml PO DAILY PRN constipation
12 Lactulose 30gm/45ml DAILY
13 Bisacodyl SUPP 10MG PR DAILY PRN
14 FLeets enema PR DAILY PRN

Pain and Dyspnea

This section is critical because pain and dyspnea are such common symptoms at the end of life. All patients should have orders for some medications in this section to ensure they have access to opioids for pain and dyspnea..

Discussion of Opioid Options

Comfort Care Opioid Orders

PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effective.
Calculate morphine equivalents used in recent past adjust as needed.
SL q2hr offer patient may refuse.
PO meds offer longer duration of action then IV/subQ.
Morphine PO to IV equivalent is 3:1.

1 Morphine 5mg SL Q2hr
2 Morphine 5mg PO Q2hr
3 Morphine 2mg SQ Q2hr
4 Morphine 1mg IV PCA Pump per Protocol
5 Morphine 500mg/NS 50ml SQ Infusion
6 Oxycodone

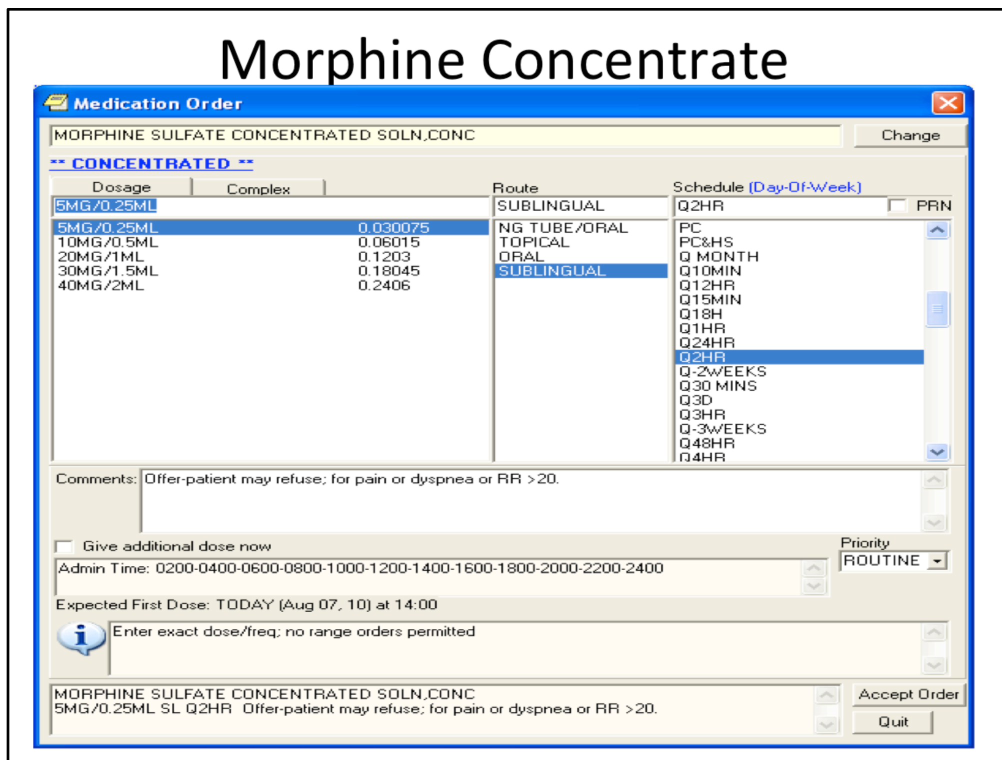
Pain and Dyspnea

The bolded section is decision support information to guide the clinician in choosing treatment options from the list below. A common barrier to adequate opioids therapy at end of life is loss of the ability to swallow pills or tablet , thus requiring a sublingual or parental route. A second problem is that patients are weak and not able to request PRN medication. In this situation, it can help to have orders indicating scheduled "offer may refuse" or "based on symptoms" administration.

The default doses for morphine sulfate are set at 5mg PO/SL or 2mg SQ, which would be equal in potency to a "Lortab 5" or "Percocet." Morphine is set as the default because it can be administered PO/SL/SQ or IV; it is an effective analgesic and is the best documented opioid for treatment of dyspnea.

A clinician could choose to use a higher dose if the patient has been on opioids and has developed tolerance, however, our research revealed that >80% of patients had received no opioids in the last 72 hours of life, such that they were, for practical purposes, opioid naïve. These orders should be seen as dose finding for the next 12-24 hours and provide guidance on choosing an effective dosing regimen for patients who do not have adequate control with the default setting.

If a patient has an established and effective opioid regimen, such as fentanyl patches or hydromorphone, and will be able to continue the regimen, this would be an appropriate choice.



General review of opioid orders:

The default is set to lower doses, such as in this case, morphine 5mg SL. The provider does have the option to choose a higher dose.

These medications are scheduled q 2 hours. This schedule may seem frequent, but it is intended to be an initial dose finding to achieve pain relief in a 4-8 hour period. If a patient is not achieving pain control with this dose finding, the clinician can use the amount administered to choose a higher dose for breakthrough or start a continuous infusion.

These medications are not ordered PRN. PRN medications are not effective at end of life, when patients have difficulty requesting medications. The nursing staff will assess if the pain medication is needed every 2 hours. If the patient can respond at all, the staff member could offer medication and the patient can decline. For non-verbal patients, the staff should use the non-verbal pain assessment and clinical judgment. If the patient has a respiratory rate of greater than 20/minute, this could indicate dyspnea that might benefit from opioids.

This approach is actually easier for nursing staff to document than PRN opioids. When a PRN medication is administered, a follow-up assessment of effectiveness is required. With this method, the nurse only has to document if the medication was given and does not have to document twice.

Morphine Concentrate

Medication Order

MORPHINE SULFATE CONCENTRATED SOLN,CONC — Change

** CONCENTRATED **

Dosage		Route	Schedule (Day-Of-Week)
5MG/0.25ML		SUBLINGUAL	Q2HR — PRN
5MG/0.25ML	0.030075	NG TUBE/ORAL	PC
10MG/0.5ML	0.06015	TOPICAL	PC&HS
20MG/1ML	0.1203	ORAL	Q MONTH
30MG/1.5ML	0.18045	SUBLINGUAL	Q10MIN
40MG/2ML	0.2406		Q12HR
			Q15MIN
			Q18H
			Q1HR
			Q24HR
			Q2HR
			Q-2WEEKS
			Q30 MINS
			Q3D
			Q3HR
			Q-3WEEKS
			Q48HR
			Q4HR

Comments: Offer-patient may refuse; for pain or dyspnea or RR >20.

Give additional dose now

Priority: ROUTINE

Admin Time: 0200-0400-0600-0800-1000-1200-1400-1600-1800-2000-2200-2400

Expected First Dose: TODAY (Aug 07, 10) at 14:00

Enter exact dose/freq; no range orders permitted

MORPHINE SULFATE CONCENTRATED SOLN,CONC
5MG/0.25ML SL Q2HR Offer-patient may refuse; for pain or dyspnea or RR >20.

Accept Order

Quit

Morphine Concentrate

Morphine concentrate is 20mg/ml and can be administered sublingually. This formulation and route for morphine are commonly used in the home hospice setting. Even patients who are not alert or able to swallow can be effectively treated for pain or dyspnea with this medication.

Although morphine SL has been used in home hospice, there have been some barriers to use in the inpatient setting. In general, there seems to be a preference for IV/SQ parental medications among physicians, nurses, patients, and families ,as this is perceived as more "effective" and also, more inline with the culture of using injections or parental medications. We have observed that the SQ option is commonly used in many of the hospitals where this CCOS has been implemented.

Another barrier is pharmacy policy that regulates dispensing of medication. It is not possible to use the bottle and dropper that is used at home and meet standards for control of the dispensing of the morphine SL. Some pharmacies have drawn the morphine concentrate up in insulin syringes, so that there is a unit dose. Others have purchased unit doses that come in 1 ml ampules with 20mg of morphine, which often leads to wasting medication each time the ampules are opened.

Morphine Solution

Medication Order

MORPHINE SULFATE SOLN,ORAL
Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

5MG
ORAL
Q2HR
PRN

Dosage	
5MG/2.5ML	0.1965
10MG/5ML	0.393
15MG/7.5ML	0.5895
20MG/10ML	0.786
30MG/15ML	1.179

Route: ORAL, NG TUBE/ORAL

Schedule: PC, PC&HS, Q MONTH, Q10MIN, Q12HR, Q15MIN, Q18H, Q1HR, Q24HR, Q2HR, Q-2WEEKS, Q30 MINS, Q3D, Q3HR, Q-3WEEKS, Q48HR, Q4HR, Q-4WEEKS, Q5MIN, Q6HR, Q72HR

Comments: Offer-patient may refuse; for pain or dyspnea or RR >20.

Give additional dose now

Priority: ROUTINE

Admin Time: 0200-0400-0600-0800-1000-1200-1400-1600-1800-2000-2200-2400

Expected First Dose: TODAY (Aug 07, 10) at 14:00

MORPHINE SULFATE SOLN,ORAL
5MG PO Q2HR Offer-patient may refuse; for pain or dyspnea or RR >20.

Accept Order
Quit

Morphine Solution

Morphine solution is a 10mg/5ml concentration that may make administration easier in some patients. If a patient has a PEG tube present (patients with history of cancers of the oro-pharynx often have had a PEG tube placed during active treatment) it is often easier to administer this solution which has more volume and then flush the feeding tube than to try to administer the more concentrated form.

The orders regarding dose, timing, and scheduling are the same as described for all opioids in the dose finding and titration phase.

Morphine Subcutaneous Injection

Medication Order

MORPHINE SULFATE INJ | Change

Dosage / Rate	Complex
2MG/1ML	0.726
4MG/1ML	0.692
8MG/1ML	1.345
10MG/1ML	0.775
15MG/1ML	0.135
15MG/1ML	0.1095
20MG/2ML	1.55
30MG/2ML	0.219

Route: SUBCUTANEOUS — IV PUSH, INTRAMUSCULAR, INTRAVENOUS, NASAL, SUBCUTANEOUS

Schedule (Day-Of-Week): Q2HR — PRN — PC, PC&HS, Q MONTH, Q10MIN, Q12HR, Q15MIN, Q18H, Q1HR, Q24HR, Q2HR, Q-2WEEKS, Q30 MINS, Q3D, Q3HR, Q-3WEEKS, Q48HR

Comments: Offer-patient may refuse; for pain or dyspnea or RR >20.

Give additional dose now

Priority: ROUTINE

Admin Time: 0200-0400-0600-0800-1000-1200-1400-1600-1800-2000-2200-2400

Expected First Dose: TODAY (Aug 07, 10) at 14:00

Outpatient Rx for this must be written on Rx Blank & signed by MD

MORPHINE SULFATE INJ
2MG/1ML SC Q2HR Offer-patient may refuse; for pain or dyspnea or RR >20.

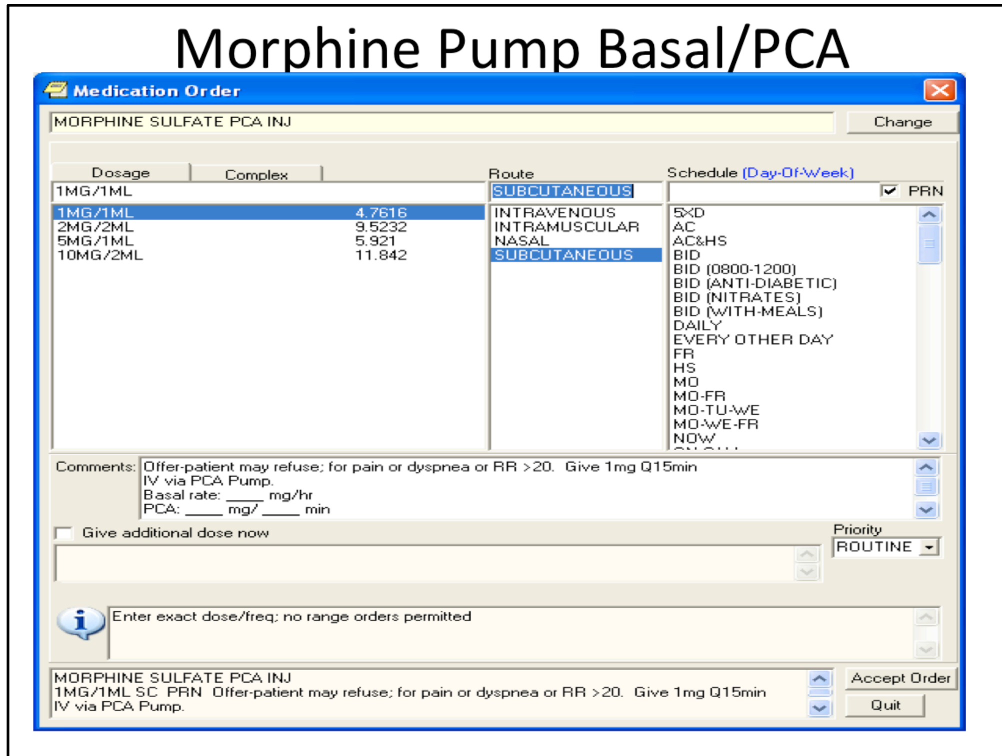
Accept Order | Quit

Morphine Sulfate 2mg SQ q 2hour schedule, offer patient may refuse or Respiratory Rate >20/minute. This order has been the most commonly used opioid order in the dose finding and titration process in facilities that have adopted the CCOS. MS 2mg SQ is comparable to the MS 5mg SL/PO dose in potency using the 3:1 ratio of potency for oral to parenteral morphine.

It should be noted that morphine IV is not recommended routinely in the CCOS. Problems encountered with morphine IV include the following:

a) The short half life (less than 10 minutes) means that the effect wanes quickly when given intermittently, with reoccurrence of pain well before the next dosing interval. If morphine is to be used IV, it is best administered as Patient Controlled Analgesia (PCA) with or without a basal rate. However, many patients at end-of-life are not alert enough to use the PCA function ,and almost all will lose capacity to use the PCA function before death .
b) Loss of the IV line is a common occurrence, which results in interruption and delay of administration of opioids when symptoms are often most problematic.
c) Maintaining and restarting IV lines causes pain and distress of in patients .

For these reasons SQ administration is recommend since the half life is longer, providing better analgesic control, and the SQ line can be easily inserted and replaced if need be, reducing the interruption and delay in administration of opioids.



Morphine Patient Controlled Analgesia (PCA)

This order is set as a default and prompts for ordering a basal rate and the PCA function. For patients who are relatively opioid naïve and able to use the PCA function, one can set the PCA for 8-12 hours , and then use the number of demands and dose s given as a guide to set a basal rate.

For patients who have been on oral opioids and are no longer able to continue the oral route, providers should use the Opioid Analgesic Dosing Card to convert to morphine equivalents and then use the 3:1 Po: IV/SQ ratio to convert to total parenteral dose for 24 hours, which when divided by 24 hours, will give the hourly rate.

It is usually recommended to start with 75% of the calculated dose and titrate up, unless the patient is in a pain crisis and clearly needs a higher dose.

Note that if a patient is not able to use the PCA function and basal dose is set , providers can use the previous MS 2 mg (or higher dose if needed) q 2hour, offer may refuse as the break-through regimen for the pump.

Morphine Infusing for Higher Concentration

Medication Order

MORPHINE HOSPICE INFUSION INJ

Change

Dosage | Complex | Route | Schedule (Day-Of-Week) | PRN

10MG/1ML

SUBCUTANEOUS

SUBCUTANEOUS
INTRAMUSCULAR
INTRAVENOUS
NASAL

5XD
AC
AC&HS
BID
BID (0800-1200)
BID (ANTI-DIABETIC)
BID (NITRATES)
BID (WITH-MEALS)
DAILY
EVERY OTHER DAY
FR
HS
MO
MO-FR
MO-TU-WE
MO-WE-FR
NOW

Comments: SUBCUTANEOUS INFUSION RATE:____

Give additional dose now

Priority
ROUTINE

CONC: 10MG/ML

MORPHINE HOSPICE INFUSION INJ
10MG/1ML SC PRN SUBCUTANEOUS INFUSION RATE:____

Accept Order

Quit

Some programs may have access to the portable CADD or infusion pumps for patients who need a chronic opioid infusion. The advantage of this form of subcutaneous infusion is that the morphine is concentrated, and this will allow the patient to go much longer between morphine reservoir exchanges. This is particularly helpful if the hourly rate is greater than 5mg. For many standard PCA pumps, the syringes contain only 60mg of morphine and will need to be changed every 12 hours. The other advantage is that the pump is smaller, not connected to a pole, and allows the patient to ambulate more easily.

The experience of the teams using the CCOS is that only a small number of patients need this modality, but it can be very helpful to control pain for that select group.

Other Opioids

Medication Order

OXYcodone IR CAP,ORAL Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

5MG | ORAL | Q4HR | PRN

Dosage		Route	Schedule
5MG	0.0539	ORAL	Q48HR
10MG	0.1078	NG TUBE/ORAL	Q4HR
		NG TUBE	Q-4WEEKS
		G TUBE	Q5MIN
		J TUBE	Q6HR
		PEG TUBE	Q72HR
			Q8HR
			Q96H
			QAM
			QAM (ANTI-DIABETIC)
			QAM&QPM
			QHS
			QHS PRN
			QID
			QID SS
			QNOON
			QPM
			QPM (ANTI-DIABETIC)

Comments: Offer patient may refuse for pain or dyspnea, do not wake RR >20/minute

Give additional dose now

Priority ROUTINE

Admin. Time: 0200-0600-1000-1400-1800-2200

Expected First Dose: TODAY (Aug 11, 10) at 14:00

Enter exact dose/freq; no range orders permitted

OXYcodone IR CAP,ORAL
5MG PO Q4HR Offer patient may refuse for pain or dyspnea, do not wake
RR >20/minute

Accept Order Quit

Other Opioids

There are a number of other opioid medications that are helpful and may be preferred in individual patients receiving palliative care.

However, listing too many options often confuses the primary care provider who may need to use the CCOS protocol. It is important to remember that oral tablets, like this oxycodone, may be a barrier to adequate opioid therapy as patients decline and are no longer able to swallow tablets. It is important to have a sublingual or subcutaneous rescue available so that response to patient distress with pain is not unduly delayed.

Other Opioids
Methadone. This is an excellent option for some patients, but dosing may be more difficult and many facilities do have parenteral methadone options available. This is an opioid for which guidance by the experienced palliative care team is needed ,and it is not safe to offer as a default medication.
Hydromorphone. This is an excellent option for some patients. There is currently no hydromorphone concentrate, so sublingual therapy is not an option. This medication can be given subcutaneously, either intermittently or using a PCA pump. This is a much more potent medication, and an experienced palliative care team should supervise therapy.
Fentanyl Patch: This option may be appropriate but should be prescribed only after dose finding is completed. Supervision by experienced providers is recommended.

Linking Laxative Therapy to Opioid Therapy

Comfort Care Opioid Orders

PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effec
Calculate morphine equivalents used in recent past adjust a
SL q2hr offer patient may refuse.
PO meds offer longer duration of action then IV/subQ.
Morphine PO to IV equivalent is 3:1.

1 Morphine 5mg SL Q2hr
2 Morphine 5mg PO Q2hr
3 Morphine 2mg SQ Q2hr
4 Morphine 1mg IV PCA Pump per Protocol
5 Morphine 500mg/NS 50ml SQ Infusion
6 Oxycodone

CONSTIPATION: Initiate if on opioids or no BM x 2 days.

7 Please check for impaction
8 Bisacodyl 5mg PO BID
9 Sennosides 17.2mg PO BID (may crush)
10 Docusate 250mg PO BID
11 MOM 30ml PO DAILY PRN constipation
12 Lactulose 30gm/45ml DAILY
13 Bisacodyl SUPP 10MG PR DAILY PRN
14 FLeets enema PR DAILY PRN

CONSTIPATION: Initiate if on opioids or no BM x 2 days.

7 Please check for impaction
8 Bisacodyl 5mg PO BID
9 Sennosides 17.2mg PO BID (may crush)
10 Docusate 250mg PO BID
11 MOM 30ml PO DAILY PRN constipation
12 Lactulose 30gm/45ml DAILY
13 Bisacodyl SUPP 10MG PR DAILY PRN
14 FLeets enema PR DAILY PRN

Constipation

There is a separate section for constipation, because it is important to order a bowel regimen whenever patients are prescribed opioids. If choices for laxatives have already been chosen when an opioid was ordered, the clinician may skip this section.

The constipation section appears later under its own heading, so that if a modification of the bowel regimen is needed, the CCOS can be opened and the clinician can easily select that section to place orders.

The first step is a nursing text order to check for impaction. Unless a rectal exam has been done the same day, it is almost always good practice to check for impaction.

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Bisacodyl

Medication Order

BISACODYL TAB,EC — Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

5MG | ORAL | BID | PRN

Dosage	
5MG	0.0226
10MG	0.0452
15MG	0.0678
20MG	0.0904

Route: ORAL

Schedule: 5XD, AC, AC&HS, BID, BID (0800-1200), BID (ANTI-DIABETIC), BID (NITRATES), BID (WITH-MEALS), DAILY, EVERY OTHER DAY, FR, HS, MO, MO-FR, MO-TU-WE, MO-WE-FR, NOW, ON CALL, ON CALL-OR, ONCE, ONE TIME

Comments:

Give additional dose now

Priority: ROUTINE

Admin Time: 0900-2100

Expected First Dose: TODAY (Aug 07, 10) at 21:00

BISACODYL TAB,EC
5MG PO BID

Accept Order | Quit

There are two large bowel stimulants, bisacodyl and senna. One of these laxatives should be used to prevent constipation when opioids are prescribed. There is no strong evidence for the superiority of one large bowel stimulant over the other. However, senna may require a larger number of tablets and pill burden may be a consideration.

The default is for one tablet BID, but can be escalated easily.

Senna

Medication Order

SENNA TAB | Change

Dosage	Complex	Route	Schedule (Day-Of-Week)
17.2MG	0.0128	ORAL	BID

Dosage		Route	Schedule
8.6MG	0.0064	ORAL	5XD
17.2MG	0.0128	NG TUBE	AC
		G TUBE	AC&HS
		J TUBE	BID
		PEG TUBE	BID (0800-1200)
			BID (ANTI-DIABETIC)
			BID (NITRATES)
			BID (WITH-MEALS)
			DAILY
			EVERY OTHER DAY
			FR
			HS
			MO
			MO-FR
			MO-TU-WE
			MO-WE-FR
			NOW
			ON CALL
			ON CALL-OR

PRN

Comments: MAY CRUSH

Give additional dose now

Admin Time: 0900-2100

Priority: ROUTINE

Expected First Dose: TODAY (Aug 07, 10) at 21:00

DISP IN MULT OF 100

SENNA TAB
17.2MG PO BID MAY CRUSH

Accept Order | Quit

Senna is an effective laxative for constipation and may be the preference of the patient or clinician. The default dose is 2 tablets BID, which is comparable to the bisacodyl dose in the previous slide.

Docusate: A Stool Softener

Medication Order

DOCUSATE SODIUM CAP,ORAL | Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

250MG | ORAL | BID | PRN

Dosage		Route	Schedule
250MG	0.0424	ORAL	5XD
500MG	0.0848	NG TUBE/ORAL	AC
		NG TUBE	AC&HS
		G TUBE	BID
		J TUBE	BID (0800-1200)
		PEG TUBE	BID (ANTI-DIABETIC)
			BID (NITRATES)
			BID (WITH-MEALS)
			DAILY
			EVERY OTHER DAY
			FR
			HS
			MO
			MO-FR
			MO-TU-WE
			MO-WE-FR
			NOW
			ON CALL
			ON CALL-OR
			ONCE
			ONE TIME
			OTHER

Comments:

Give additional dose now

Priority: ROUTINE

Admin Time: 0900-2100

Expected First Dose: TODAY (Aug 07, 10) at 21:00

DOCUSATE SODIUM CAP,ORAL
250MG PO BID

Accept Order

Quit

Docusate

This is a stool softener, not a laxative. It is commonly given with senna or bisacodyl to aid with elimination. Docusate only is not adequate for opioid constipation prophylaxis.

Response to No Bowel Movement in Last 2 Days

Medication Order

BISACODYL SUPP,RTL

Change

Dosage | Complex | Route | Schedule (Day-Of-Week) | PRN

1 SUPPOSITORY 10MG | RECTAL | DAILY

1 SUPPOSITORY 10MG
2 SUPPOSITORIES 10MG

RECTAL

5XD
AC
AC&HS
BID
BID (0800-1200)
BID (ANTI-DIABETIC)
BID (NITRATES)
BID (WITH-MEALS)
DAILY
EVERY OTHER DAY
FR
HS
MO
MO-FR
MO-TU-WE
MO-WE-FR
NOW
ON CALL
ON CALL-OR
ONCE

Comments: If now bowel movement in the last 2 days

Give additional dose now

Priority ROUTINE

Admin. Time: 0900

Expected First Dose: TOMORROW (Aug 13, 10) at 09:00

DISP PER SUPPOSITORY

BISACODYL SUPP,RTL 10MG
1 SUPPOSITORY RTL DAILY If now bowel movement in the last 2 days

Accept Order

Quit

Bisacodyl Suppository

In patients very near the end of life, the ability to take oral laxatives often declines. Although oral intake also may decline, patients can still experience discomfort. Checking for impaction and using a suppository is a first response. Obviously, in an actively dying patient, this may not be required.

Fleets Enema

Medication Order

Na BIPHOSPHATE & Na PO4 ENEMA, (4.5oz) ENEMA | Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

1 UNIT OF ENEMA, NA PHOSPHATE 4.5OZ EA | RECTAL | DAILY | PRN

1 UNIT OF ENEMA, NA PHOSPHATE 4.5OZ EA
2 UNITS OF ENEMA, NA PHOSPHATE 4.5OZ EA

RECTAL

5XD
AC
AC&HS
BID
BID (0800-1200)
BID (ANTI-DIABETIC)
BID (NITRATES)
BID (WITH-MEALS)
DAILY
EVERY OTHER DAY
FR
HS
MO
MO-FR
MO-TU-WE
MO-WE-FR
NOW
ON CALL
ON CALL-OR
ONCE
ONE TIME
OTHER

Comments: MAY REPEAT X1

Give additional dose now

Priority: ROUTINE

ENEMA, NA PHOSPHATE 4.5OZ EA
1 UNIT RTL DAILY PRN MAY REPEAT X1

Accept Order | Quit

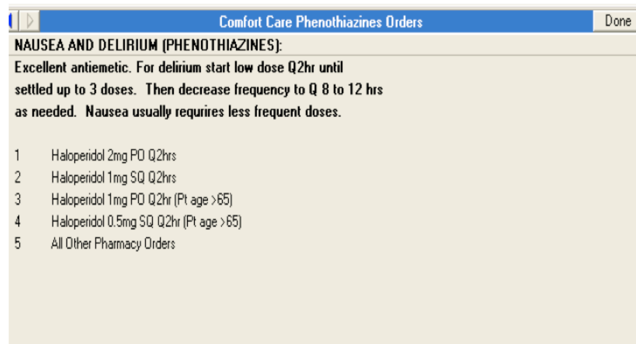
Fleets Enema

Some selected patients may benefit from a small enema, rather than a suppository. This is an option for nursing staff to use at their discretion for patient safety.

Other treatments for constipation:

1) Polyethylene Glycol (Miralax) is an effective laxative and may be a good adjuvant to a laxative plan.
2) Methylnaltrexone injection is an opioid antagonist for mu receptors in the large bowel and can stimulate a bowel movement in patients with opioid induced constipation. This is a rescue medication and is needed when inadequate attention to a laxative program has occurred leading to obstipation or, more rarely, when there is unrelieved constipation in intractable case.
3) There is limited information on the relative merits of various types of enemas. With limited evidence available, it has been our practice to use tap water with castile soap, rather than lactulose, molasses, or other mixtures.

Nausea and Delirium (Phenothiazines)



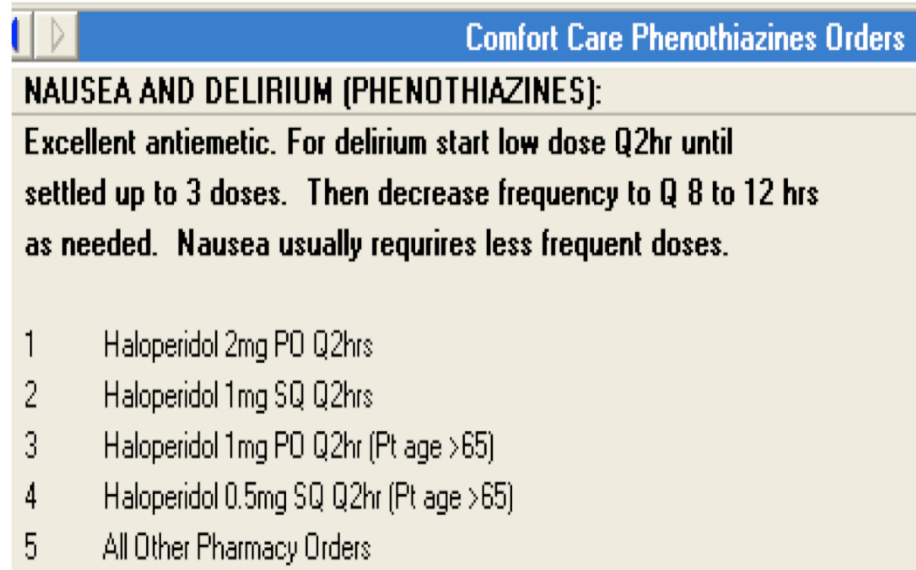
Nausea and Delirium (Phenothiazines)

Part of the goal of the CCOS is to encourage a Portmanteau approach to treatment of symptoms. This means to use a relatively small number of medications that may benefit a number of symptoms and have flexibility in administration.

The options for treatment of both delirium and nausea/vomiting are many. It would be the role of the hospice and palliative care team to provide expertise to choose wisely, however, it is ideal to have a first line treatment option.

Haloperidol was chosen for this role, because it is effective for both delirium and nausea/vomiting and can be given PO, IV, or SQ. If not adequately effective after 12-24 hours, the palliative care team can adjust the regimen.

The Cochrane Library review of the treatment of delirium concluded that low dose haloperidol was safe and effective when compared to other medication options. Haloperidol is also closely related to droperidol. Both work through the dopamine receptors in the CTZ. These medications have similar modes of action as proclorperazine (Compazine) or metoclopramide. Therefore, haloperidol is helpful for two common symptoms simultaneously.



Nausea and Delirium (Phenothiazines)

Haloperidol orders have 4 simple choices. There are haloperidol orders based on age, with higher doses for younger patients (less than 65) and dose reduction for older patients. The medication can also be ordered PO or SQ. The SQ dose is half the oral dose, because it is more potent in this form. It is advised that an order be placed, so that that staff can respond quickly in case symptoms arise.

The observation of the BEACON research team has been that the SQ route is most commonly used. Delirious patients are often unable to take an oral medication safely and taking an oral medication when nauseated or vomiting is difficult.

If a different medication is desired, there is an option to go to the pharmacy menu directly.

Haloperidol Order Examples

Medication Order

HALOPERIDOL INJ,SOLN Change

Dosage Complex Route Schedule (Day-Of-Week)

1MG SUBCUTANEOUS Q2HR ☑ PRN

1MG/0.2ML 0.1696
2MG/0.4ML 0.3392
2.5MG/0.5ML 0.424
5MG/1ML 0.848
10MG/2ML 1.696

INTRAMUSCULAR
INTRAVENOUS
SUBCUTANEOUS

PC
PC&HS
Q MONTH
Q10MIN
Q12HR
Q15MIN
Q18H
Q1HR
Q24HR
Q2HR
Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM

Comments: Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 5mg in 24 hours

Give additional dose now

Priority ROUTINE

HALOPERIDOL INJ,SOLN
1MG SC Q2HR PRN Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 5mg in 24 hours

Accept Order

Quit

The following four pages are examples of the four order options for the management of delirium or nausea/vomiting.

Note the following features of the haloperidol order.

Haloperidol is ordered as a PRN (as needed) medication and is not scheduled.
The order is for an initial dose to be administered followed by q 2hour doses for no more than a total of 3 doses or until settled. This means that, if a single dose relieves the distressing symptoms of delirium, then additional doses may be given every 8 hours as needed.

Many patients may need 2, or less commonly, 3, doses to control distressing symptoms of delirium. The order allows for dose finding and titration to customize the medication to the patient's symptoms at the lowest effective dose, while at the same time, achieving control of distressing symptoms in 4-6 hours. If a patient does not have adequate control of symptoms in this time frame, treatment recommendations are needed from the hospice and palliative care team.

It may be desirable to place a lock-out order to prevent exceeding a maximum dose over a 24-hour period.

Haloperidol Order Examples

Medication Order

HALOPERIDOL TAB — Change

Dosage	Complex
2MG	
0.5MG	0.023
1MG	0.0817
2MG	0.051
4MG	0.102
5MG	0.0992
10MG	0.1984

Route: ORAL

ORAL
NG TUBE
G TUBE
J TUBE
PEG TUBE

Schedule (Day-Of-Week): Q2HR ☑ PRN

PC
PC&HS
Q MONTH
Q10MIN
Q12HR
Q15MIN
Q18H
Q1HR
Q24HR
Q2HR
Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS
QHS PRN

Comments: Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 6 mg in 24 hours

☐ Give additional dose now

Priority: ROUTINE

HALOPERIDOL TAB
2MG PO Q2HR PRN Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 6 mg in 24 hours

Accept Order
Quit

This is the example of the oral haloperidol order for patients less than 65 years of age

Haloperidol Order Examples

Medication Order

HALOPERIDOL TAB | Change

Dosage	Complex
1MG	
0.5MG	0.023
1MG	0.0817
2MG	0.051
4MG	0.102
5MG	0.0992
10MG	0.1984

Route: ORAL

ORAL
NG TUBE
G TUBE
J TUBE
PEG TUBE

Schedule (Day-Of-Week): Q2HR ☑ PRN

PC
PC&HS
Q MONTH
Q10MIN
Q12HR
Q15MIN
Q18H
Q1HR
Q24HR
Q2HR
Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS

Comments: Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 5 mg in 24 hours

☐ Give additional dose now

Priority: ROUTINE

HALOPERIDOL TAB
1MG PO Q2HR PRN Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 5 mg in 24 hours

Accept Order | Quit

Example of the haloperidol subcutaneous route with geriatric dosing

The haloperidol orders are dose-adjusted for geriatric patients (65 years of age and older). These lower doses may be appropriate for younger patients, if they have debility or low body weight.

The operational aspects are the same for all of the haloperidol order options. Some providers will order both an oral and subcutaneous route to provide flexibility to nursing staff.

Haloperidol Order Examples

Medication Order

HALOPERIDOL INJ,SOLN — Change

Dosage	Complex
0.5MG	
1MG/0.2ML	0.1696
2MG/0.4ML	0.3392
2.5MG/0.5ML	0.424
5MG/1ML	0.848
10MG/2ML	1.696

Route: SUBCUTANEOUS
INTRAMUSCULAR
INTRAVENOUS
SUBCUTANEOUS

Schedule (Day-Of-Week): Q2HR ☑ PRN
PC
PC&HS
Q MONTH
Q10MIN
Q12HR
Q15MIN
Q18H
Q1HR
Q24HR
Q2HR
Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM

Comments: Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 3mg in 24 hours

☐ Give additional dose now

Priority: ROUTINE

HALOPERIDOL INJ,SOLN
0.5MG SC Q2HR PRN Up to 3 doses total or until settled, then q8hrs PRN, for nausea & delirium. Do not exceed 3mg in 24 hours

Accept Order — Quit

Example of the haloperidol oral route with geriatric dosing

The haloperidol orders are dose-adjusted for geriatric patients (65 years of age and older). These lower doses may be appropriate for younger patients if they have debility or low body weight.

The operational aspects are the same for all of the haloperidol order options. Some providers will order both an oral and subcutaneous route to provide flexibility to nursing staff.

Example of Other Medication Option

Comfort Care Phenothiazines Orders

Done

NAUSEA AND DELIRIUM (PHENOTHIAZINES):
Excellent antiemetic. For delirium start low dose Q2hr until
settled up to 3 doses. Then decrease frequency to Q 8 to 12 hrs
as needed. Nau

1 Haloperidol
2 Haloperidol
3 Haloperidol
4 Haloperidol
5 All Other Ph

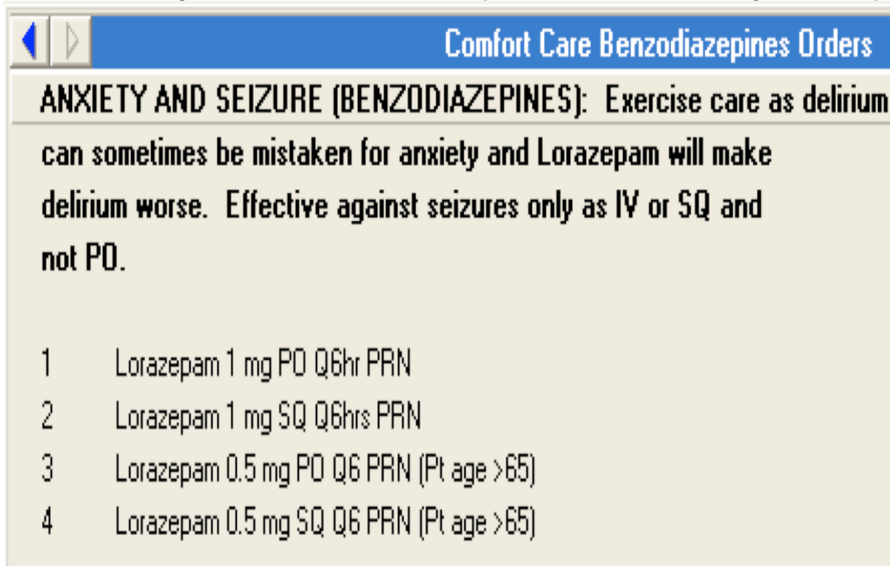
VistaWe

Medication Order

(No quick orders available)

125261 <WAFER WAFER >
125262 <WAFER WAFER >
401932 <POUCH,OSTOMY POUCH >
0.45% NACL/5% DEXTROSE <DEXTROSE 5%/SODIUM CHLORIDE 0.45% INJ,SOLN >
0.45%NS <SODIUM CHLORIDE 0.45% INJ >
0.9% NACL <SODIUM CHLORIDE 0.9% (Bacteriostatic) INJ >
0.9% NACL <SODIUM CHLORIDE 0.9% (PRES. FREE) INJ >
0.9% NACL <SODIUM CHLORIDE 0.9% FLUSH INJ >
0.9% NACL <SODIUM CHLORIDE 0.9% INJ >
0.9% NACL IRRIGATION <SODIUM CHLORIDE 0.9% IRRIG. SOLN,IRRG >
0.9% SODIUM CHLORIDE <SODIUM CHLORIDE 0.9% (Bacteriostatic) INJ >
0.9% SODIUM CHLORIDE <SODIUM CHLORIDE 0.9% FLUSH INJ >

If providers need to order a different medication for delirium or nausea, they can do so without leaving the order set.



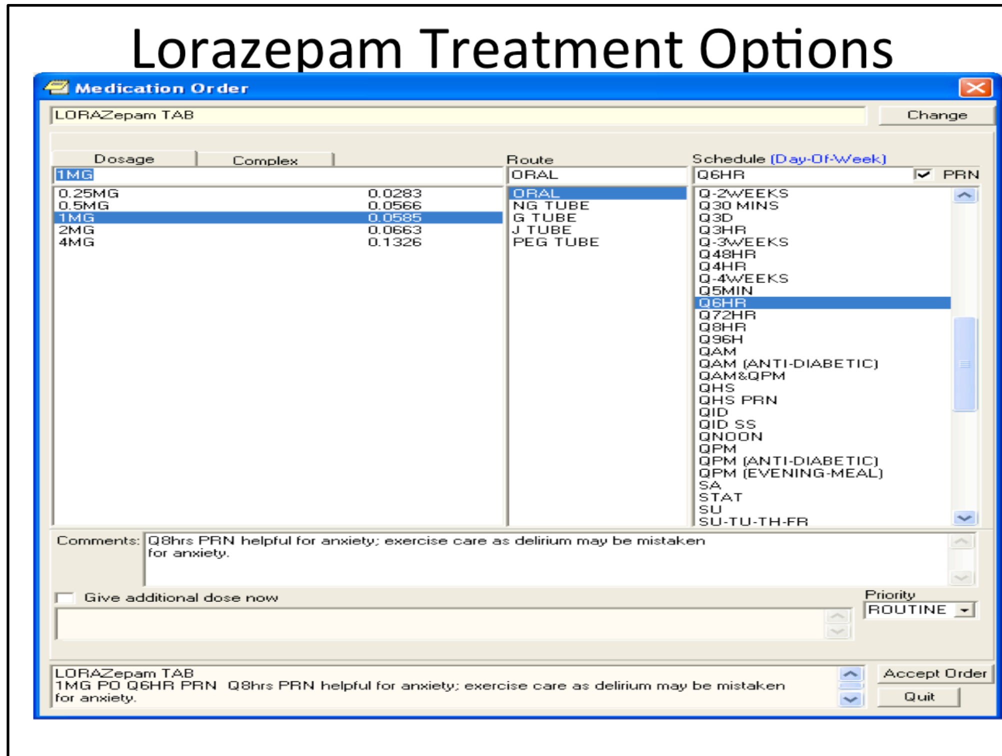
Anxiety and Seizures

Anxiety and seizures are distressing symptoms that can occur in patients at the end of life. Using the Portmanteau medication guideline, lorazepam is a good choice for a benzodiazepine, because it can be given PO, IV, or SQ and is effective also as an anticonvulsant.

The use of benzodiazepines at end of life must be carefully monitored due to the risk of mistaking delirium for anxiety and the risk of inducing delirium with this medication. Nonetheless, many patients are anxious due to their illness and/or experience worsening anxiety due to other treatments. A good example of this is COPD, in which dyspnea is commonly a cause of anxiety and albuterol may contribute as well.

Note that lorazepam is an effective anticonvulsant when given IV/SQ, but not PO. Patients with history of seizures or who have a disease process, such as brain metastases , may develop seizures when they are no longer able to take oral anticonvulsants, making this a good option.

There are four order options with either oral or parenteral routes and dose adjustment for older patients.



Lorazepam for Anxiety and Seizures

Lorazepam 1mg PO q 6HR PRN

Note the following features of these orders:

Lorazepam is always ordered as a PRN (as needed) medication as the default. If a patient has been on scheduled benzodiazepines, then changing the order to “scheduled “by clicking off the PRN button may be appropriate to prevent withdrawal.

There is a warning to nursing staff to consider delirium first as a cause of anxiety and agitation and to consider whether treatment for delirium may be indicated first.

There are orders for both oral and parenteral forms of lorazepam. Remember that only parenteral forms should be used to treat seizures.

Lorazepam Treatment Options

Medication Order

LORAZEPAM INJ

Change

Dosage / Rate | Complex | Route | Schedule (Day-Of-Week)

1MG/0.5ML | SUBCUTANEOUS | Q6HR | PRN

Dosage	
0.5MG/0.25ML	0.128
1MG/0.5ML	0.256
2MG/1ML	0.512
3MG/1.5ML	0.768
4MG/2ML	1.024
6MG/3ML	1.536

IV PUSH
INTRAMUSCULAR
INTRAVENOUS
NASAL
SUBCUTANEOUS

Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS
QHS PRN
QID
QID SS

Comments: Q8hrs PRN helpful for anxiety; exercise care as delirium may be mistaken for anxiety.

Give additional dose now

Priority: ROUTINE

DISP PER INJ (10/BOX)

LORAZEPAM INJ
1MG/0.5ML SC Q6HR PRN Q8hrs PRN helpful for anxiety; exercise care as delirium may be mistaken

Accept Order

Quit

Lorazepam 1mg IV/SQ q 6HR PRN

Lorazepam is always ordered as a PRN (as needed) medication as the default. If a patient has been on scheduled benzodiazepines, then changing the order to “scheduled” by clicking off the PRN button may be appropriate to prevent withdrawal.

There is a warning to nursing staff to consider delirium first as a cause of anxiety and agitation and to consider whether treatment for delirium may be indicated first.

There are orders for both oral and parenteral forms of lorazepam. Remember that only parenteral forms should be used to treat seizures.

Lorazepam Treatment Options

Medication Order

LORAZepam TAB

Change

Dosage | Complex

1MG

0.25MG 0.0283
0.5MG 0.0566
1MG 0.0585
2MG 0.0663
4MG 0.1326

Route

ORAL

ORAL
NG TUBE
G TUBE
J TUBE
PEG TUBE

Schedule (Day-Of-Week)

Q6HR

PRN

Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS
QHS PRN
QID
QID SS
QNOON
QPM
QPM (ANTI-DIABETIC)
QPM (EVENING-MEAL)
SA
STAT
SU
SU-TU-TH-FR

Comments: Q8hrs PRN helpful for anxiety; exercise care as delirium may be mistaken for anxiety.

Give additional dose now

Priority

ROUTINE

LORAZepam TAB
1MG PO Q6HR PRN Q8hrs PRN helpful for anxiety; exercise care as delirium may be mistaken for anxiety.

Accept Order

Quit

Lorazepam 0.5MG PO q 6HR PRN

Example of the lorazepam oral route with geriatric dosing

The lorazepam orders are dose-adjusted for geriatric patients (65 years of age and older). These lower doses may be appropriate for younger patients if they have debility or low body weight.

The operational aspects are the same for all of the lorazepam order options. Some providers will order both an oral and subcutaneous route to provide flexibility to nursing staff.

Lorazepam Treatment Options

Medication Order

LORAZEPAM INJ

Change

Dosage / Rate	Complex
0.5MG/0.25ML	
0.5MG/0.25ML	0.128
1MG/0.5ML	0.256
2MG/1ML	0.512
3MG/1.5ML	0.768
4MG/2ML	1.024
6MG/3ML	1.536

Route: SUBCUTANEOUS

IV PUSH
INTRAMUSCULAR
INTRAVENOUS
NASAL
SUBCUTANEOUS

Schedule (Day-Of-Week): Q6HR ☑ PRN

Q-2WEEKS
Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM

Comments: Helpful for anxiety; exercise care as delirium maybe mistaken for anxiety.

☐ Give additional dose now

Priority: ROUTINE

DISP PER INJ (10/BOX)

LORAZEPAM INJ
0.5MG/0.25ML SC Q6HR PRN Helpful for anxiety; exercise care as delirium maybe mistaken for anxiety.

Accept Order

Quit

Lorazepam 0.5MG IV/SQ q 6HR PRN

Example of the lorazepam subcutaneous route with geriatric dosing

The lorazepam orders are dose-adjusted for geriatric patients (65 years of age and older). These lower doses may be appropriate for younger patients if they have debility or low body weight.

The operational aspects are the same for all of the lorazepam order options. Some providers will order both an oral and subcutaneous route to provide flexibility to nursing staff.

Corticosteroid

Comfort Care Corticosteroid Orders

PAIN DYSPNEA ANOREXIA ASTHENIA AND DEPRESSION: (Corticosteroid).

Dexamethasone has less mineral corticoid effect than Prednisone.

AM dosing prefered due to insomnia.

Dexamethasone 1mg is equivalent to Prednisone 6mg.

10 Dexamethasone 4 to 8 mg PO BID with meals

11 Dexamethasone 4 to 8 mg SQ BID (subq not compatible with hydromophone)

Corticosteroids

Corticosteroids are helpful adjuvant medications for many patients at the end of life. This class of medication can help with pain by reducing inflammation. For patients with dyspnea, corticosteroids may help reactive airway disease. Many patients experience improvement in appetite and energy level, although the effects are usually short-lived, lasting a few weeks to a month.

There are some relative contraindications to corticosteroids, such as infection, increase in serum glucose, delirium, and insomnia. However, for many patients, the benefits are likely to be greater than the burden of a trial of treatment.

The CCOS advocates for the use of dexamethasone as the corticosteroid of choice in this setting. Dexamethasone has flexibility, in that it can be given PO, IV/, or SQ and is of equivalent strength in oral and parenteral forms. No other commonly used corticosteroid has this flexibility. Because dexamethasone has little mineral corticoid effects, fluid retention may be less common. Dexamethasone is relatively more likely to cause increases in serum glucose than some other forms, but has not been a common issue in clinical practice.

Dexamethasone

Medication Order

DEXAMETHASONE TAB | Change

Dosage		Route	Schedule (Day-Of-Week)
4MG		ORAL	BID (0800-1200) PRN
0.5MG	0.0355	ORAL	5XD
0.75MG	0.057	NG TUBE	AC
1MG	0.071	G TUBE	AC&HS
1.5MG	0.1046	J TUBE	BID
2MG	0.03075	PEG TUBE	BID (0800-1200)
3MG	0.2092		BID (ANTI-DIABETIC)
4MG	0.0615		BID (NITRATES)
8MG	0.123		BID (WITH-MEALS)
12MG	0.1845		DAILY
16MG	0.246		EVERY OTHER DAY
			FR
			HS
			MO
			MO-FR
			MO-TU-WE
			MO-WE-FR
			NOW
			ON CALL
			ON CALL-OR
			ONCE
			ONE TIME
			OTHER
			PC
			PC&HS
			Q MONTH

Complex

Comments: Give with breakfast & lunch

Give additional dose now

Priority: ROUTINE

Admin Time: 0800-1200

Expected First Dose: TOMORROW (Aug 08, 10) at 08:00

DEXAMETHASONE TAB
4MG PO BID (0800-1200) Give with breakfast & lunch

Accept Order | Quit

Dexamethasone

Note the following features of this order:

The orders for dexamethasone call for 4mg or 8mg twice a day at breakfast and noon.

Dexamethasone 4mg is approximately equivalent to prednisone 15mg. Therefore, dexamethasone 16mg per day is equivalent to prednisone 60mg /day, which will provide nearly the maximum anti-inflammatory effect.

Dexamethasone has a very long half-life and could probably be given as a daily dose with equivalent effects. It is clear that giving corticosteroids in the evening may lead to insomnia and potentially more risk of delirium. Although dexamethasone is often given in multiple daily doses, such as q 6 hours, and at much higher doses, such as a total of 40-100mg/day, the benefit of these strategies is not clearly demonstrated.

This order plan of dosing at breakfast and lunch was chosen because providers did not feel comfortable with once a day dosing, and this takes advantage of a potent potential placebo effect by administering the medication with meals.

Dexamethasone

Medication Order

DEXAMETHASONE INJ,SOLN | Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

4MG/1ML | SUBCUTANEOUS | BID (0800-1200) | PRN

Dosage	
4MG/1ML	0.538
6MG/1.5ML	0.807
8MG/2ML	1.076
10MG/2.5ML	1.345
12MG/3ML	1.614

Route: INTRAMUSCULAR/IN, INTRAMUSCULAR, INTRAVENOUS, SUBCUTANEOUS

Schedule: 5XD, AC, AC&HS, BID, BID (0800-1200), BID (ANTI-DIABETIC), BID (NITRATES), BID (WITH-MEALS), DAILY, EVERY OTHER DAY, FR, HS, MO, MO-FR, MO-TU-WE, MO-WE-FR, NOW, ON CALL, ON CALL-OR, ONCE, ONE TIME

Comments: May give SQ if PO meds not tolerated. Give with breakfast & lunch.

Give additional dose now

Priority: ROUTINE

Admin Time: 0800-1200

Expected First Dose: TOMORROW (Aug 08, 10) at 08:00

DISPENSE PER EACH (ML) (1ML VIAL)-IV USE RESTRICTED TO ER/ICU

DEXAMETHASONE INJ,SOLN
4MG/1ML SC BID (0800-1200) May give SQ if PO meds not tolerated. Give with breakfast & lunch.

Accept Order | Quit

Dexamethasone SQ/IV

This order is the parenteral version of the oral version and may be used if the oral route is compromised. It is easy to convert back to oral, if desired, and adjust the dose up or down as needed.

This order plan of dosing at breakfast and lunch was chosen because providers did not feel comfortable with once a day dosing and this takes advantage of a potent potential placebo effect by administering the medication with meals.

If the medication is effective, the provider will want to adjust to the lowest dose to maintain the desired effect. If not as effective after a few days, the dose can be escalated.

This medication is particularly helpful if the patient has been on corticosteroids, loses the oral route, and needs to have the medication maintained. It should be noted that dexamethasone has little mineral corticoid effect, and if this effect is desired, a different medication, such as fludrocortisone may be needed.

Constipation

Comfort Care Constip

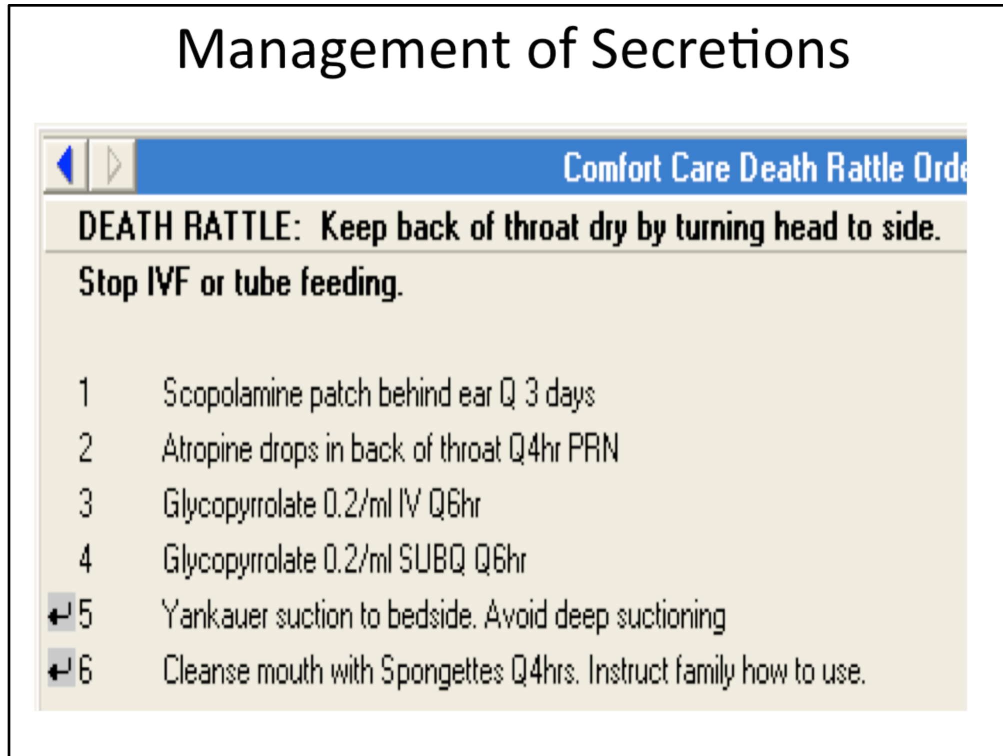
CONSTIPATION: Initiate if on opioids or no BM x 2 days.

1 Please check for impaction
2 Bisacodyl 5mg PO BID
3 Sennosides 17.2mg PO DAILY (may crush)
4 Docusate 250mg PO BID
5 MOM 30ml PO DAILY PRN constipation
6 Lactulose 30gm/45ml DAILY
7 Bisacodyl SUPP 10MG PR DAILY PRN
8 FLeets enema PR DAILY PRN

Constipation

Note that this has been discussed in relationship to the prompt to order a bowel regimen when ordering opioids. However, since some patients may not be on opioids or because a clinician may want to open the CCOS and to modify the treatment plan for constipation, it has its own section.

All of the options are the same as was discussed previously.



Management of Secretions

Loud, moist breathing at the end of life can be very distressing for families and staff. Patients usually seem to have a lowered level of consciousness and do not seem very distressed. However, families are often concerned that their loved one is suffering.

Repositioning and stopping fluids and tube feedings can be helpful. However, frequent deep suctioning does not appear to be very helpful and certainly can be uncomfortable for the patient .

The following menu offers a number of options for management of secretions. The relative superiority of one approach over another has not been determined. However, all of the medications work by drying the mouth and throat.

These medications contribute to decreased level of consciousness and delirium. Not all patients need these medications. It is important to not start these medications before they are needed, due to their potentially troubling side effects.

Management of Secretions

Medication Order

SCOPOLAMINE TRANSDERMAL PATCH | Change

Dosage | Complex | Route | Schedule (Day-Of-Week)

1 PATCH | TOPICAL | Q72HR | PRN

1 PATCH 0.33MG/24HRS NF

TOPICAL
TOPICAL MISCELLAN

Q30 MINS
Q3D
Q3HR
Q-3WEEKS
Q48HR
Q4HR
Q-4WEEKS
Q5MIN
Q6HR
Q72HR
Q8HR
Q96H
QAM
QAM (ANTI-DIABETIC)
QAM&QPM
QHS
QHS PRN
QID
QID SS
QNOON
QPM
QPM (ANTI-DIABETIC)
QPM (EVENING-MEAL)
SA
STAT
SU
SU-TU-TH-FR
SU-TU-TH-SA
SU-TU-WE-FR-SA

Comments: Place behind ear.

Give additional dose now

Priority: ROUTINE

Admin Time: 0900

Expected First Dose: TOMORROW (Aug 08, 10) at 09:00

SCOPOLAMINE TRANSDERMAL PATCH
1 PATCH TOP Q72HR Place behind ear.

Accept Order

Scopolamine Patches

This medication has often been used in the home hospice setting. One advantage is that the patch can be placed and will not need to be replaced for most patients ,due to relatively short life-expectancy of patients who have a “death rattle.” On the other hand, the medication could take considerable time to take effect, due to absorption time and the scopolamine may linger in the subcutaneous depot if the medication is discontinued.

For these reasons, some providers will want to use one of the more rapid onset medications following this option until the secretions are adequately controlled or in lieu of scopolamine or if prognosis is thought to be only hours.

In some VA pharmacies, this medication is listed as non-formulary and extra steps may be involved to procure it.

Atropine Drops

Medication Order

ATROPINE SULFATE 1% SOLN,OPH — Change

Dosage	Route	Schedule (Day-Of-Week)
2 DROPS 1%	ORAL	Q4HR ☑ PRN
1 DROP 1%	OPHTHALMIC	Q1HR
2 DROPS 1%	RIGHT EYE	Q24HR
3 DROPS 1%	LEFT EYE	Q2HR
ONE DROP 1%	BOTH EYES	Q-2WEEKS
TWO DROPS 1%		Q30 MINS
THREE DROPS 1%		Q3D
		Q3HR
		Q-3WEEKS
		Q48HR
		Q4HR
		Q-4WEEKS
		Q5MIN
		Q6HR
		Q72HR
		Q8HR
		Q96H
		QAM
		QAM (ANTI-DIABETIC)
		QAM&QPM
		QHS
		QHS PRN

Comments: X24HR Until Scopolamine patch effective.

Give additional dose now

Priority: ROUTINE

DISPENSE PER ML (15ML/BTL)

ATROPINE SULFATE 1% SOLN,OPH 1%
TWO DROPS ORAL Q4HR PRN X24HR Until Scopolamine patch effective.

Accept Order | Quit

Atropine Eye Drops

Atropine is know to dry oral secretions. This treatment has also been used in the home hospice setting and is convenient, because it can be given orally.

It is important to note that the drops are of atropine ophthalmic solution, and the directions are to place in the back of the throat. If using this approach, it is important to explain this non-standard use of the medication to family, nursing staff ,and pharmacy.

A note in this order alerts nursing staff that use of atropine is particularly important as an intermittent measure if a scopolamine patch has been placed.

Glycopyrrolate

Medication Order

GLYCOPYRROLATE INJ INJ,SOLN Change

Dosage	Complex	Route	Schedule (Day-Of-Week)
0.2MG/1ML		SUBCUTANEOUS	Q6HR PRN

Dosage	
0.2MG/1ML	0.1236
0.2MG/1ML	0.1532
0.2MG/1ML	0.2628
0.3MG/1.5ML	0.1854
0.4MG/2ML	0.2472
0.4MG/2ML	0.3064

Route: INTRAMUSCULAR, INTRAVENOUS, SUBCUTANEOUS

Schedule: Q-2WEEKS, Q30 MINS, Q3D, Q3HR, Q-3WEEKS, Q48HR, Q4HR, Q-4WEEKS, Q5MIN, Q6HR, Q72HR, Q8HR, Q96H, QAM, QAM (ANTI-DIABETIC), QAM&QPM, QHS, QHS PRN, QID, QID SS, QNOON, QPM, QPM (ANTI-DIABETIC), QPM (EVENING-MEAL), SA, STAT

Comments:

Give additional dose now

Priority ROUTINE

Admin Time: 0600-1200-1800-2400

Expected First Dose: TODAY (Aug 07, 10) at 18:00

GLYCOPYRROLATE INJ INJ,SOLN
0.2MG/1ML SC Q6HR

Accept Order

Quit

Glycopyrrolate

Some providers prefer to use glycopyrrolate for management of secretions. This medication is given by a parenteral route and, fortunately, can be given either subcutaneously or by IV. The subcutaneous route has been used most often in the BEACON program, because it is easier to maintain access.

For patients with secretions that are very difficult to control, an increase in the dose or an increase in frequency (to q 4) may be considered.

Mouth Care

Comfort Care Death Rattle Orde

DEATH RATTLE: Keep back of throat dry by turning head to side. Stop IVF or tube feeding.

1 Scopolamine patch behind ear Q 3 days
2 Atropine drops in back of throat Q4hr PRN
3 Glycopyrrolate 0.2/ml IV Q6hr
4 Glycopyrrolate 0.2/ml SUBQ Q6hr
5 Yankauer suction to bedside. Avoid deep suctioning
6 Cleanse mouth with Spongettes Q4hrs. Instruct family how to use.

Mouth Care

Patients at the end of life often need and benefit from mouth care. All patients who receive medication for secretions are likely to have a dry mouth and lips and benefit from mouth care.

This slide demonstrates the two mouth care orders.

One order is for a Yankauer suction set up. Although deep suctioning is discouraged, patients cough or spit up material into the front of the mouth and a Yankauer is helpful with clearing this material.

Spongettes with water can be used to clean and moisten the mouth. Patients often benefit mouth care more often than the order of Q 4hours. Therefore the order suggests that if family wish to participate in care, that mouth care is something they can be taught.

Additional Comfort Orders

Comfort Care Additional

Please schedule medication if symptoms are continuous.

Fever:
1 Acetaminophen tab 650mg po q 4hr prn
2 Acetaminophen supp 650mg pr q 4hr prn
Insomnia:
3 Trazodone 25mg po qhs prn
Dry eyes:
4 Methylcellulose 0.4% opth sol 2 gtts each eye q6hr
5 Lacri Lube opth oint thin ribbon of Lacri Lube both eyes 6qhr
Sore mouth:
6 Mylanta benedryl lidocaine visc susp 30cc po ac prn
7 Cetylpyridinium mouthwash 1 rinse of 0.05% topical qid prn
Thrush:
8 Nystatin 100000UT/ml 5ml po qid x 7d
Sore throat:
9 Phenol spray 1.4% 2puffs of 1.4% qid
Cough:
10 Guaifenesin 100mg/5ml po q6hr
Hiccoughs:
11 Baclofen 10mg po tid prn
12 Chlorpromazine 25mg po q6hr prn
Dyspepsia:
13 Maalox plus extr str 30ml po q6hr prn
14 Ranitidine 150mg po bid
15 Omeprazole 20mg po qd
Diarrhea:
Call MD for Lomotil & C.Diff orders.
16 Pepto Bismol 262mg qid prn
Dysuria:
17 Phenazopyridine 100mg po tid x 2d

Additional Comfort Medications

When the CCOS was first developed this section was not available. However, it became clear that many of the orders in the CCOS were good options for patients who were actively dying, as well as patients earlier in their hospital or nursing home (community living center) stay. Therefore, this menu option was created to remind providers of other medications that might be helpful and to save them the time of having to enter the orders through the pharmacy menu.

Demonstration of Menu

Comfort Care Additional Comfort Orders — Done

Please schedule medication if symptoms are continuous.

Fever:
1 Acetaminophen tab 650mg po q 4hr prn
2 Acetaminophen supp 650mg pr q 4hr
Insomnia:
3 Trazodone 25mg po qhs prn
Dry eyes:
4 Methylcellulose 0.4% opth sol 2 gtts e
5 Lacri Lube opth oint thin ribbon of Lac
Sore mouth:
6 Mylanta benedryl lidocaine visc susp
7 Cetylpyridinium mouthwash 1 rinse of
Thrush:
8 Nystatin 100000UT/ml 5ml po qid x 7
Sore throat:
9 Phenol spray 1.4% 2puffs of 1.4% qid
Cough:
10 Guaifenesin 100mg/5ml po q6hr
Hiccoughs:
11 Baclofen 10mg po tid prn
12 Chlorpromazine 25mg po q6hr prn
Dyspepsia:
13 Maalox plus extr str 30ml po q6hr prn
14 Ranitidine 150mg po bid
15 Omeprazole 20mg po qd
Diarrhea:
Call MD for Lomotil & C.Diff orders.
16 Pepto Bismol 262mg qid prn
Dysuria:
17 Phenazopyridine 100mg po tid x 2d

Medication Order

traZODONE TAB — Change

Dosage		Route	Schedule (Day-Of-Week)
25MG		ORAL	QHS PRN (PRN)
25MG	0.02965	ORAL	Q5MIN
50MG	0.0593	NG TUBE	Q6HR
75MG	0.08895	G TUBE	Q72HR
100MG	0.0861	J TUBE	Q8HR
150MG	0.12915	PEG TUBE	Q96H
200MG	0.1722		QAM
			QAM (ANTI-DIABETIC)
			QAM&QPM
			QHS
			QHS PRN
			QID

Comments: PRN INSOMNIA, MAY REPEAT IN 1HR

Give additional dose now — Priority: ROUTINE

Enter exact dose/freq; no range orders permitted

traZODONE TAB
25MG PO QHS PRN PRN INSOMNIA, MAY REPEAT IN 1HR

Accept Order — Quit

Menu Option Demonstrated

All of these options are open to a default setting of the lower dose and most common route and frequency. These options can be accepted or the order can be customized easily by the clinician.

Additional Comfort Orders

Comfort Care Additional Comfo

Please schedule medication if symptoms are continuous.

Fever:
1 Acetaminophen tab 650mg po q 4hr prn
2 Acetaminophen supp 650mg pr q 4hr prn
Insomnia:
3 Trazodone 25mg po qhs prn
Dry eyes:
4 Methylcellulose 0.4% opth sol 2 gtts each eye q6hr
5 Lacri Lube opth oint thin ribbon of Lacri Lube both eyes 6qhr
Sore mouth:
6 Mylanta benedryl lidocaine visc susp 30cc po ac prn
7 Cetylpyridinium mouthwash 1 rinse of 0.05% topical qid prn
Thrush:
8 Nystatin 100000UT/ml 5ml po qid x 7d
Sore throat:
9 Phenol spray 1.4% 2puffs of 1.4% qid

Additional Comfort Medications:

Fever
1) Tylenol PO
2) Tylenol PR

Insomnia
3) Trazodone 25mg q HS PRN

Dry Eyes
4) HYPROMELLOSE 0.4% W/BAK OPHTH SOLN,OPH 2 drops q 6 hours
5) Lacri Lube Ointment to eyes q 6hours

Sore Mouth
6) MYLANTA/BENADRYL/XYLOCAINE VISC SUSP,ORAL q AC PRN
7) CETYLPYRIDINIUM MOUTHWASH PRN MOUTH PAIN, SWISH AND SWALLOW

Thrush
8) NYSTATIN ORAL TAB,ORAL 1000000UNT PO QID SWISH AND SWALLOW

Sore Throat
9) PHENOL SPRAY,ORAL QID PRN PRN DYSPHAGIA

Additional Comfort Orders

Cough:
10 Guaifenesin 100mg/5ml po q6hr
Hiccoughs:
11 Baclofen 10mg po tid prn
12 Chlorpromazine 25mg po q6hr prn
Dyspepsia:
13 Maalox plus extr str 30ml po q6hr prn
14 Ranitidine 150mg po bid
15 Omeprazole 20mg po qd
Diarrhea:
Call MD for Lomotil & C.Diff orders.
16 Pepto Bismol 262mg qid prn
Dysuria:
17 Phenazopyridine 100mg po tid x 2d

Additional Comfort Medications (Continued)

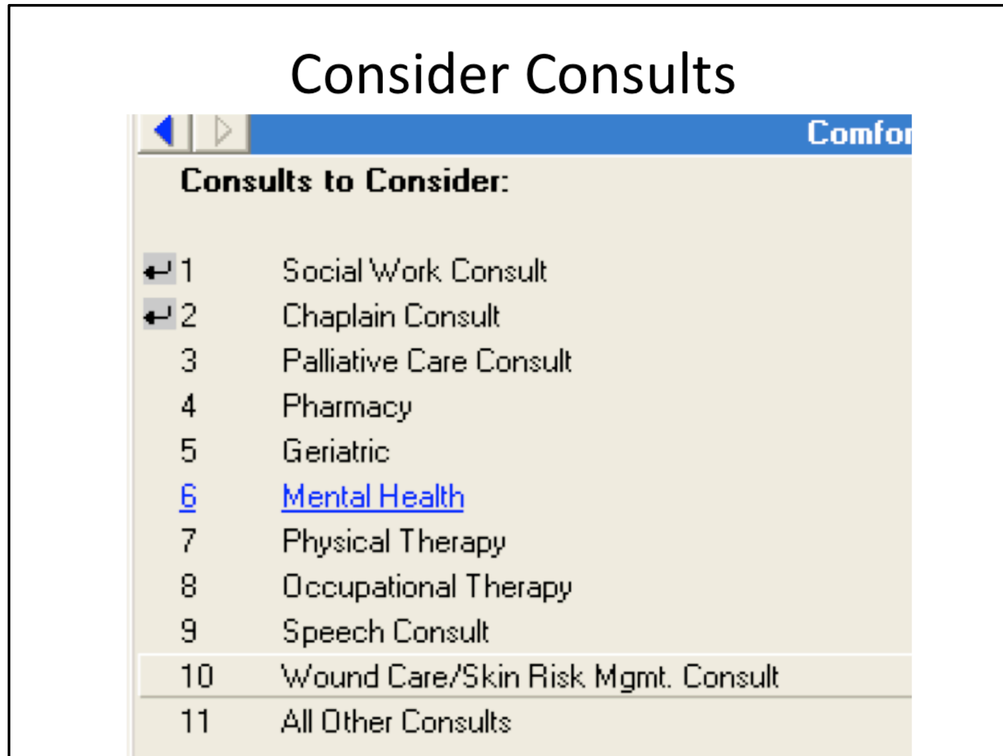
Cough
10) Guaifenesin 5ml q 6 hours PRN

Hiccoughs
11) Baclofen 10mg PO TID PRN
12) Chlorpromazine 25mg PO q 6 hours PRN

Dyspepsia
13) Maalox plus 30ml PO q 6 hours PRN
14) Ranitidine 150 mg PO BID
15) Omeprazole 20mg PO daily

Diarrhea
Call MD for and Clostridium Difficile orders
16) Pepto Bismol 262 mg q 6 hours PRN

Dysuria
17) PHENAZOPYRIDINE HCL TAB 100MG PO TID



Consider Consults

Hospice and Palliative Care patients are best served by an interdisciplinary team approach. Typically, they have multiple needs, making it prudent to consult one or more supporting services.

One of the consult options is “Palliative Care.” Because any clinician may encounter patients at end of life, they may wish to consider using the CCOS. They may use the CCOS to begin palliation of symptoms immediately and place a consult to the Palliative Care Consult Team to assist, refine, or potentially transfer the patient if it is appropriate.

Example of Consult Open

Order a Consult

Consult to Service/Specialty: MENTAL HEALTH - INPATIENT PSYCHIATRY

MENTAL HEALTH - INPATIENT PSYCHIATRY

Urgency: ROUTINE

Attention:

Patient will be seen as an: Inpatient / Outpatient

Place of Consultation: BEDSIDE

Provisional Diagnosis: [Lexicon]

Reason for Request

```
SERVICE CONNECTED % - NONE FOUND
========================================================================
RATED DISABILITIES - NONE FOUND
========================================================================
Enrollment Priority: GROUP 5 / Combat Veteran Status: None Indicated
========================================================================
```

MENTAL HEALTH - INPATIENT PSYCHIATRY Cons BEDSIDE

[Accept Order] [Quit]

When a consult is selected, the clinician is prompted to fill out the consult form with additional information that service may need to respond appropriately.

After placing all of the needed consults, the CCOS is complete. Additional orders such as for laboratory studies, radiology studies , other medications, or any other needs can be placed using the usual order tabs in the system.

Comfort Care Order Set BEACON PROJECT

Comfort Care Order Sets

- Helpful guide to care for Veterans in the hospital who have severe and life limiting illness to improve
  - Allows the physicians to order admission, transfer to new unit in hospital or start order set in less than 10 minutes
  - Comprehensive so fewer calls for new prn medications or cross cover issues
  - Symptom control of pain and other symptoms
  - Improve patient and family satisfaction

Comfort Care Order Set

- Safe and Easy to use orders for pain medications, medications for delirium and agitation and other symptoms
- Prewritten nursing text orders for comfort measures that you don't have to type in.
- By using the entire order set less likely to forget to place an order that results in call back, cross cover issues or poor symptom control.

Comfort Care Order Set

Comfort Care Order Menu | Done

Comfort Care Orders Menu

1	Admit and initiate Comfort Care Order Set
2	Transfer and initiate Comfort Care Order Set
3	DNI DNR
4	Diet Orders
5	Nursing
6	Vital Signs
7	Activity Orders
8	IV Considerations
9	Respiratory Orders
10	Pain & Dyspnea (Opioids)
11	Nausea & Delirium (Phenothines)
12	Anxiety and Seizure (Benzodiazepines)
13	Pain Dyspnea Anorexia Asthenia and Depression (Corticosteroids)
14	Constipation
15	Death Rattle Orders
16	Additional Comfort Medications
17	Consults

Designation of Resuscitation Status

DNR Orders

Next

Per Policy Resident DNR/DNI order active X 24hr after discussing with Attending

DNI X 24 HOURS (RESIDENT ORDER)

DNI ATTENDING ORDER

DNR X 24 HRS (RESIDENT ORDER)

DNR ATTENDING ORDER

REMOVE DNI (REMOVES DNI POSTING FROM COVER SHEET)

REMOVE DNR (REMOVES DNR POSTING FROM COVER SHEET)

Patient Care Order

Patient Care

DNR

Instructions

DO NOT ATTEMPT RESUSCITATION

Start Date/Time

NOW

Stop Date/Time

DNR
DO NOT ATTEMPT RESUSCITATION

Accept Order

Quit

Full Liquid Diet instead of NPO

Diet Orders | Next

DIET

Order a diet. Patient may improve and desire to taste food.
Order Full Liquid diet instead of clear liquids. More palatable.
Easier to swallow. Less likely to cause aspiration. Advance as tolerated.
May have food brought in by family. Allow patient to sit and eat. Assist to eat.

Full Liquid Diet
May have food brought in by family
Allow patient to sit up for meals. Assist to eat.

Other Diet Orders

Nursing Orders

Comfort Care Nursing Orders — Done

NURSING:

TIPS FOR COMFORT/SAFETY:
Comforting measures. Reposition. Massage. Speak to patient.
Soft music. Avoid sensory overload (TV).

1 Please weigh on admission to Safe Harbor and weekly on Mondays thereafter
2 For CHF please weigh daily
3 May discontinue lab tests and daily wts and SCD's and subq Heparin and discontinue telemetry
4 RN may change form of medicine and route of administration. No IM meds
5 Keep hearing aid and dentures and glasses on pt.
6 Audiology consult:obtain amplifier for HOH patient
7 If actively dying please turn only for comfort
8 Please designate the patient HOSPICE FOR ACUTE CARE

ACTIVITY: AVOID RESTRAINTS. Patient may need one on one sitter.

Begin environment modifications:

9 OOB to chair BID and preferably outside
10 Open curtain during day.
11 Decrease unnecessary noise (turn off TV)
12 Redirect ~ Reposition ~ Speak quietly
13 Provide nightlight when sleeping.
14 Please allow family to stay with patient in room

ASSISTING FAMILY:
Advise family about alerting their family members as to gravity of pt status. Arrange family visits of military relatives by contacting Red Cross and of incarcerated relatives by contacting warden. SW may assist.

15 Please give family "Preparing For Your Loved One's Loss"

Vital Signs

Comfort Care Vitals Orders Done

VITAL SIGNS: Minimal frequency allowed by policy.
Limit notification orders to those necessary.
Frequent monitors can distract staff/family from patient.

1 Routine Vital Signs Q8hrs
2 Notify Attending for Palliative Care Patient
3 If greater than 2 days since last BM please check for impaction
place 2 bisacodyl supp If no results notify MD

Suggested Notifications

Notify

Respiratory Status: Labored breathing not relieved with medication

Agitation: Agitation/Delirium not relieved with medication

Pain: Pain not controlled with medication

Family Present: Family present and need to speak with physician

Special Instructions: Comfort Care Order

Start date: T ...

Stop date: T+21 ...

Notify MD if:
Labored breathing not relieved with medication
Agitation/Delirium not relieved with medication
Pain not controlled with medication
Family present and need to speak with physician

Accept Order

Quit

SQ Lines, IV and Fluids

◁ ▷ **IV Considerations** Next

IV Placement often difficult & painful without patient benefit
Presence of edema indicates that patient is not dehydrated
Many patients have fluid overload edema and pulmonary congestion
If IV fluids used suggest limited time trial of D5 1/2NS 1000 ml over 6 hours
Suggest oral hydration as a reasonable compromise or

D5 1/2NS 1000cc IV over 6 hours
Other IV Fluid Orders

Subcutaneous Line: Small IV (22 gauge) needle inserted directly under skin (often on the abdomen or thigh) Avoids burden of finding/maintaining IV access. For injecting small volumes of many medicines when oral route unavailable

Subcutaneous (SQ) Line

Hypodermoclysis (subcutaneous infusion)

D5 1/2NS 1000cc SQ over 24 hours

Subcutaneous Line Placement

Subcutaneous (SQ) Line

Order: Insert small gauge IV needle for SQ access
directly under the skin (abdomen or thigh)
For injecting small volumes of medications when oral route unavailable

Special Instructions: Comfort Care Order

Start Date: Now ...

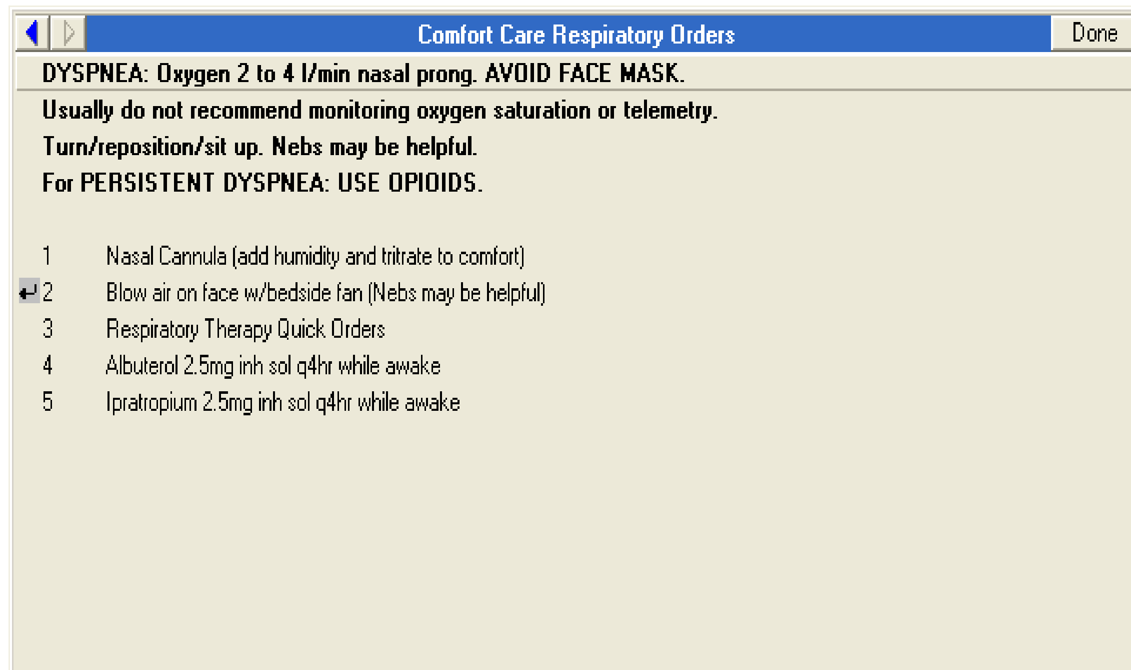
Stop Date: T+21 ...

Insert small gauge IV needle for SQ access
directly under the skin (abdomen or thigh)
For injecting small volumes of medications when oral route unavailable
Comfort Care Order
Start Date: Now
Stop Date: T+21

Accept Order

Quit

Oxygen and Respiratory Therapy



Comfort Care Respiratory Orders — Done

DYSPNEA: Oxygen 2 to 4 l/min nasal prong. AVOID FACE MASK.

Usually do not recommend monitoring oxygen saturation or telemetry.

Turn/reposition/sit up. Nebs may be helpful.

For PERSISTENT DYSPNEA: USE OPIOIDS.

1 Nasal Cannula (add humidity and titrate to comfort)
2 Blow air on face w/bedside fan (Nebs may be helpful)
3 Respiratory Therapy Quick Orders
4 Albuterol 2.5mg inh sol q4hr while awake
5 Ipratropium 2.5mg inh sol q4hr while awake

Oxygen Nasal Cannula Default

Nasal Oxygen

Order: NASAL OXYGEN

Special Instructions: For patient comfort avoid face mask

Special Instructions: Comfort Care Order

Start Date: Now

Stop Date: T+7

NASAL OXYGEN 2-4L/M - Nasal Cannula
For patient comfort avoid face mask
Comfort Care Order
Start Date: Now
Stop Date: T+7

Accept Order

Quit

Bed Side Fan for Air Flow

Fan for patient room

Special Instructions: Comfort Care Order

Order Start: N

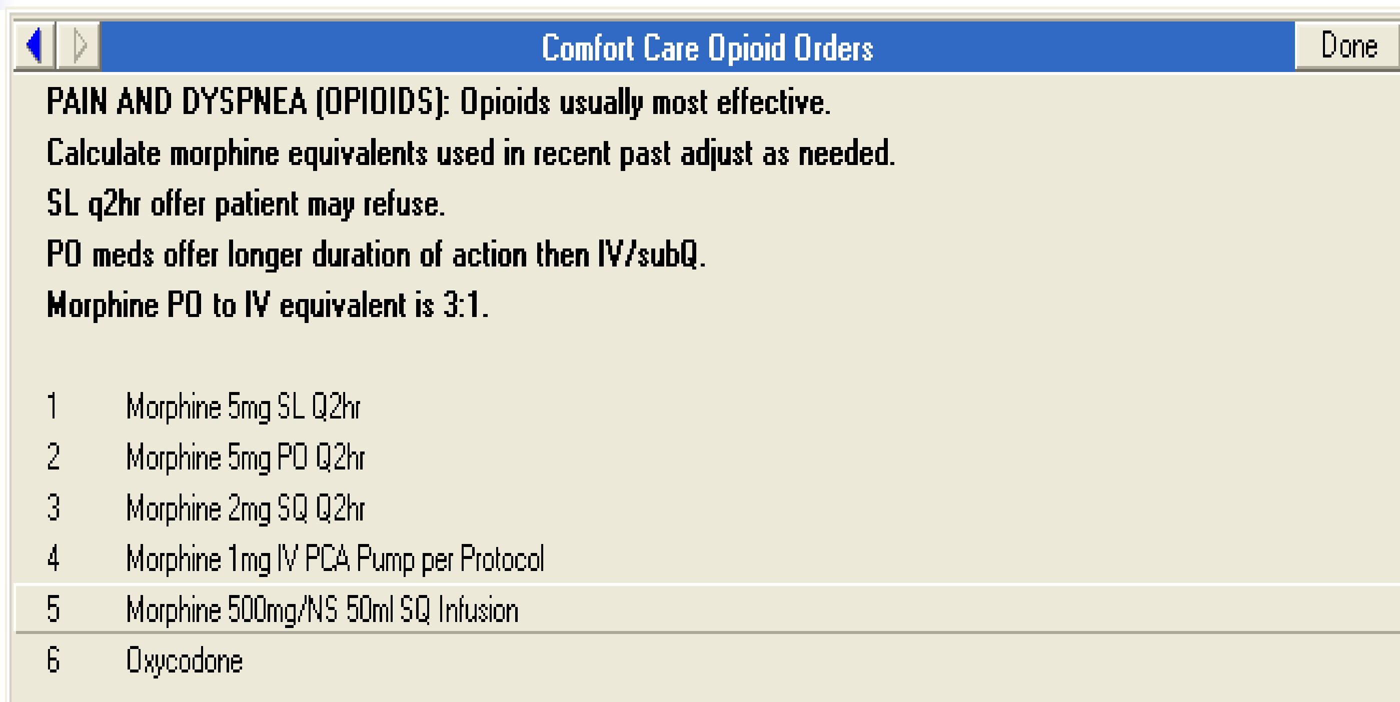
Order Stop: T+21

Blow air on face with bedside Fan
Comfort Care Order
Order Start: N
Order Stop: T+21

Accept Order

Quit

Most Patients at Life's End have Pain or Dyspnea and Need an Opioid


Comfort Care Opioid Orders

Done

PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effective.

Calculate morphine equivalents used in recent past adjust as needed.

SL q2hr offer patient may refuse.

PO meds offer longer duration of action then IV/subQ.

Morphine PO to IV equivalent is 3:1.

1	Morphine 5mg SL Q2hr
2	Morphine 5mg PO Q2hr
3	Morphine 2mg SQ Q2hr
4	Morphine 1mg IV PCA Pump per Protocol
5	Morphine 500mg/NS 50ml SQ Infusion
6	Oxycodone

Oral Morphine Solution Example of Offer/ May Refuse

Medication Order

MORPHINE SULFATE CONCENTRATED SOLN,CONC | Change

** CONCENTRATED **

Dosage | Complex

5MG/0.25ML

Dosage	
5MG/0.25ML	0.030075
10MG/0.5ML	0.06015
20MG/1ML	0.1203
30MG/1.5ML	0.18045
40MG/2ML	0.2406

Route: SUBLINGUAL

- NG TUBE/ORAL
- TOPICAL
- ORAL
- SUBLINGUAL

Schedule (Day-Of-Week): Q2HR — PRN

- PC
- PC&HS
- Q MONTH
- Q10MIN
- Q12HR
- Q15MIN
- Q18H
- Q1HR
- Q24HR
- Q2HR
- Q-2WEEKS
- Q30 MINS
- Q3D
- Q3HR
- Q-3WEEKS
- Q48HR
- Q4HR

Comments: Offer-patient may refuse; for pain or dyspnea or RR >20.

Give additional dose now

Priority: ROUTINE

Admin Time: 0200-0400-0600-0800-1000-1200-1400-1600-1800-2000-2200-2400

Expected First Dose: TODAY (Aug 07, 10) at 14:00

Enter exact dose/freq; no range orders permitted

MORPHINE SULFATE CONCENTRATED SOLN,CONC
5MG/0.25ML SL Q2HR Offer-patient may refuse; for pain or dyspnea or RR >20.

Accept Order | Quit

Patient May Need Parenteral Medication if Problem Swallowing

Medication Order

MORPHINE INJ — Change

If for PRN use enter an Indication for Use in the "Comments" field

Dosage / Rate | Complex

2MG/0.5ML

Dosage	
1MG/0.25ML	0.173
2MG/0.5ML	0.346
3MG/0.75ML	0.519
4MG/1ML	0.692
5MG/0.5ML	0.3875
6MG/0.6ML	0.465
7MG/0.7ML	0.5425
8MG/0.8ML	0.62
10MG/1ML	0.775
15MG/1ML	0.537
15MG/1ML	5.51
30MG/2ML	11.02

Route

INTRAVENOUS

- INTRAVENOUS
- INTRAMUSCULAR
- IRRIGATION
- SUBCUTANEOUS
- INTRA-ARTICULAR

Schedule (Day-Of-Week)

Q2H — PRN

- PC&HS
- PM
- PRN
- Q12H
- Q12H PRN
- Q18H
- Q1H
- Q1H PRN
- Q24H
- Q2H
- Q2H PRN
- Q2WEEKS
- Q36H
- Q3H
- Q3H PRN
- Q3MIN PRN
- Q3-MINX3 PRN/CP
- Q3WEEKS
- Q48H
- Q4H
- Q4H PRN
- Q4WEEKS
- Q5MIN PRN

Comments: Comfort Care Order: Offer - Patient may refuse: for pain or dyspnea or RR>20.

Give additional dose now

Priority: ROUTINE

Admin Time: 01-03-05-07-09-11-13-15-17-19-21-23

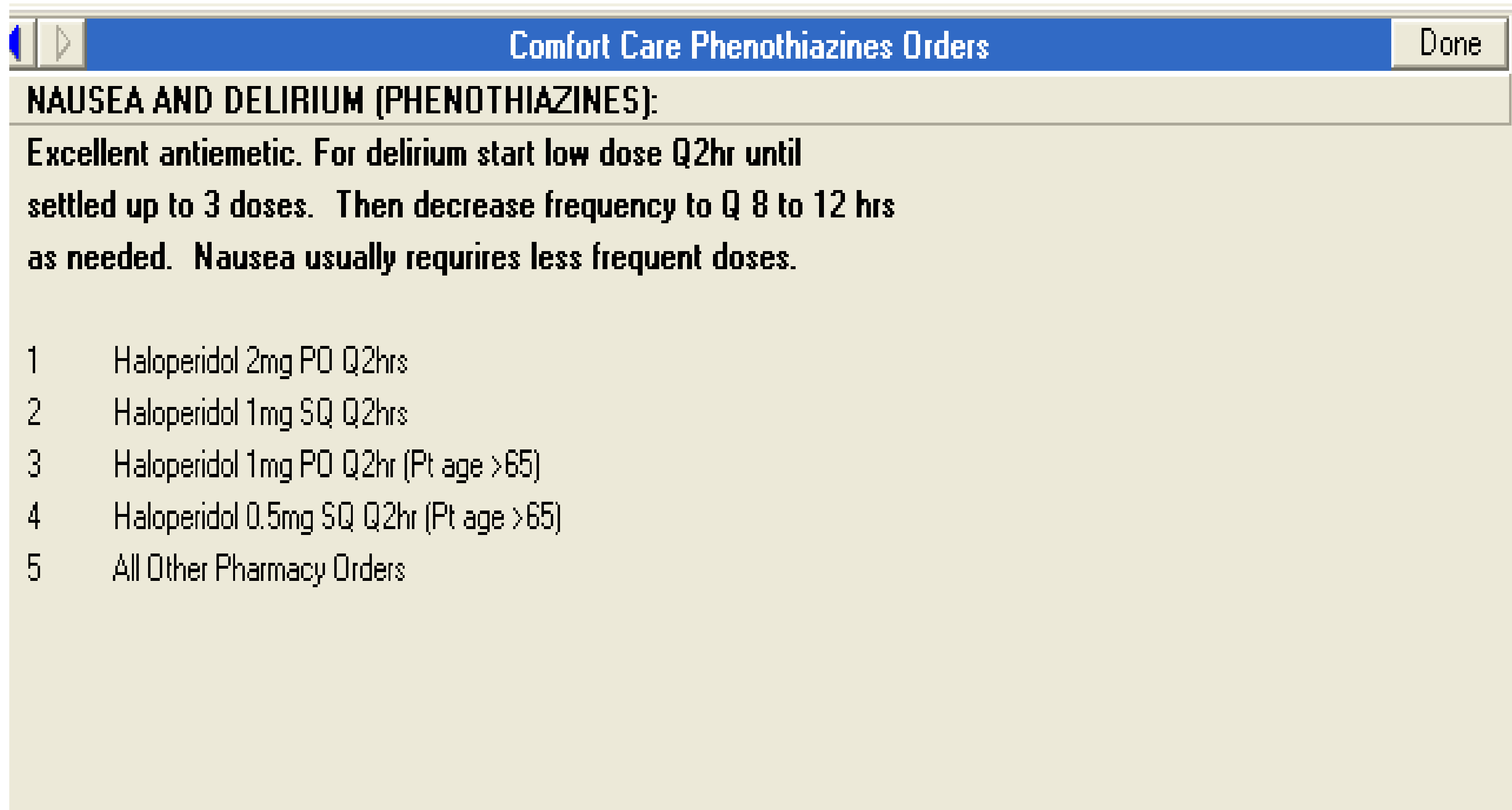
Expected First Dose: TODAY (Oct 14, 09) at 13:00

MORPHINE INJ
2MG/0.5ML IV Q2H Comfort Care Order: Offer - Patient may refuse: for pain or dyspnea or RR>20.

Accept Order

Quit

Different Routes and Doses Depending on Age and Patient



Haloperidol is helpful for: Delirium and Nausea/Vomiting

Medication Order

HALOPERIDOL INJ,SOLN

Change

If for PRN use enter an Indication for Use in the "Comments" field

Insert Row | Remove Row

Dosage | Complex

(Day-Of-Week)

Dosage	Route	Schedule	Duration (opti	Admin. Times	then/and
1MG/0.2ML	INTRAVEN	Q2H	6 HOURS	01-03-05-07-09-11	THEN
1MG/0.2ML	INTRAVEN	Q6H PRN			

Comments: Up to 3 doses total or until settled then Q6H PRN for nausea/delirium. Not to exceed 3 doses (3mg) in 24 hours without notifying provider (Comfort Care Order)

Give additional dose now

Priority: ROUTINE

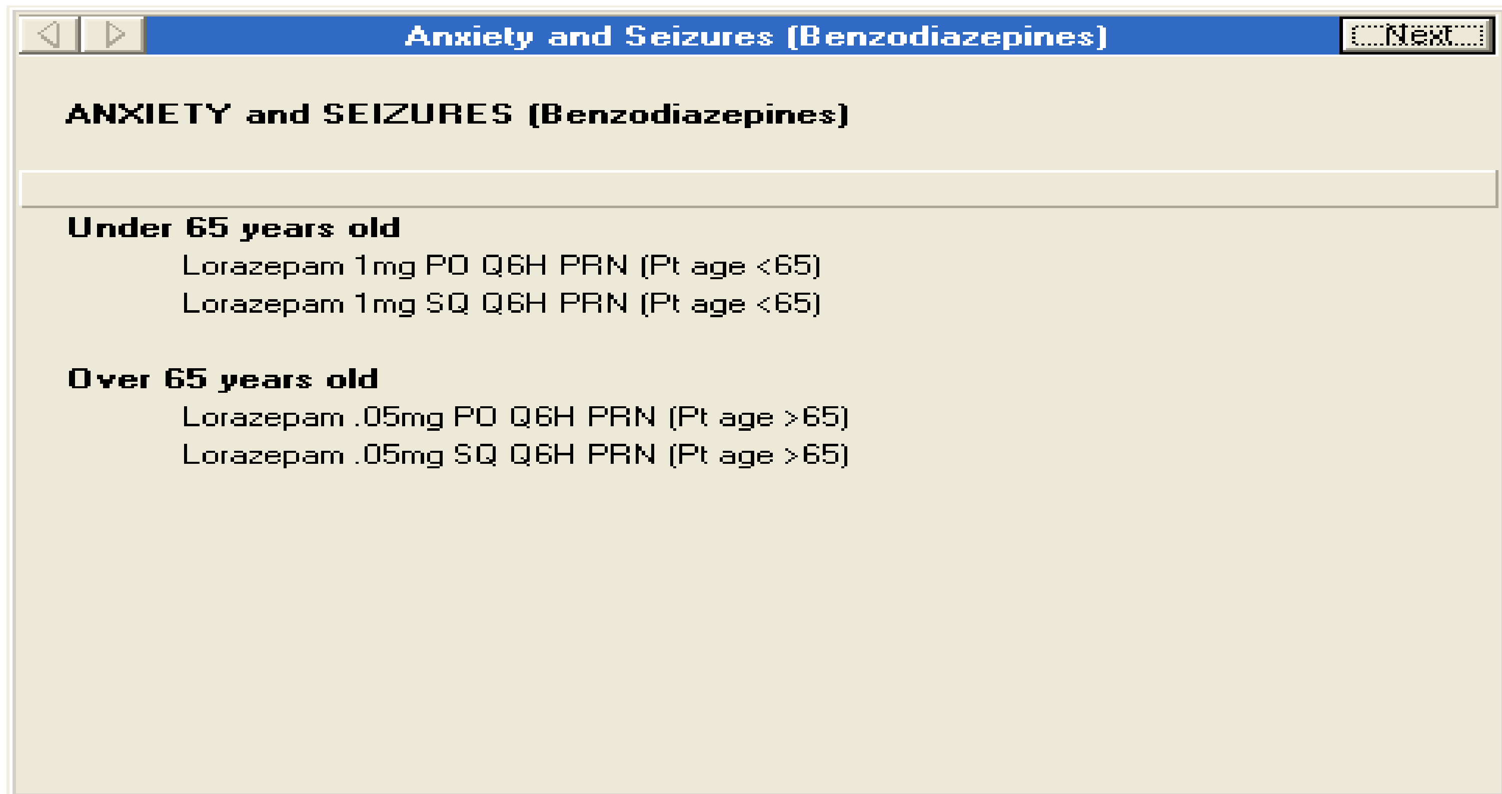
Expected First Dose: TODAY (Oct 14, 09) at 13:00

HALOPERIDOL INJ,SOLN
1MG/0.2ML IV Q2H FOR 6 HOURS THEN 1MG/0.2ML IV Q6H PRN Up to 3 doses total or until settled then Q6H PRN for

Accept Order

Quit

Lorazepam for Anxiety and Seizure Note Different Routes/Doses for Ages



Lorazepam orders SQ; PRN; Delirium Warning

Medication Order

LORAZEPAM INJ
Change

Display Restrictions/Guidelines

Dosage | Complex | Route | Schedule (Day-Of-Week)

1MG/0.5ML
INTRAVENOUS
Q6H PRN
PRN

0.5MG/0.25ML 0.39825
1MG/0.5ML 0.7965
2MG/0.5ML 1.1795
4MG/1ML 2.359

INTRAMUSCULAR
INTRAVENOUS
IRRIGATION
SUBCUTANEOUS
INTRA-ARTICULAR

Q3MIN PRN
Q3-MINX3 PRN/CP
Q3WEEKS
Q48H
Q4H
Q4H PRN
Q4WEEKS
Q5MIN PRN
Q6H
Q6H PRN
Q72H
Q8H
Q8H PRN
Q96H
QAM
QAM INSULIN
QHS
QHS PRN
QID
QID PRN
QPM
QPM INSULIN
RESP-BID
RESP-Q6H
RESP-Q6H PRN
RESP-QID

Comments: For anxiety or seizure (Comfort Care Order)
Note: Delirium may be mistaken for anxiety. If delirium suspected, see Haloperidol orders.

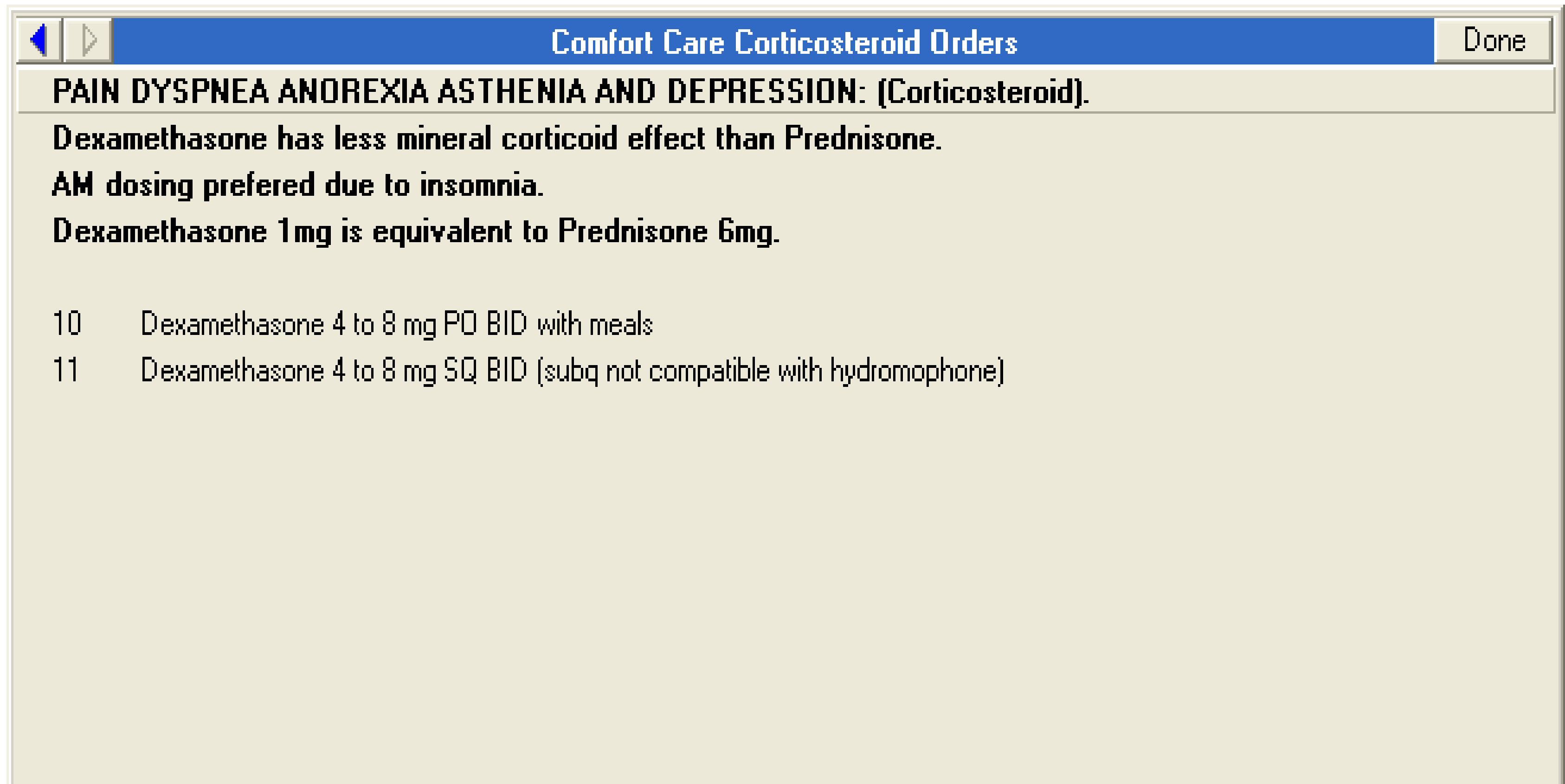
Give additional dose now

Priority
ROUTINE

LORAZEPAM INJ
1MG/0.5ML IV Q6H PRN For anxiety or seizure (Comfort Care Order)
Note: Delirium may be mistaken for anxiety. If delirium suspected, see

Accept Order
Quit

Corticosteroids Often Help Multiple Symptoms



For Death Rattle

Comfort Care Death Rattle Orders Done

DEATH RATTLE: Keep back of throat dry by turning head to side.

Stop IVF or tube feeding.

1. Scopolamine patch behind ear Q 3 days.
2. Atropine drops in back of throat Q4hr PRN
3. Glycopyrrolate 0.2/ml IV Q6hr
4. Glycopyrrolate 0.2/ml SUBQ Q6hr
5. Yankauer suction to bedside. Avoid deep suctioning
6. Cleanse mouth with Spongettes Q4hrs. Instruct family how to use.

Consider Consults

Comfort Care Consult Orders | Done

Consults to Consider:

1	Social Work Consult
2	Chaplain Consult
3	Palliative Care Consult
4	Pharmacy
5	Geriatric
6	Mental Health
7	Physical Therapy
8	Occupational Therapy
9	Speech Consult
10	Wound Care/Skin Risk Mgmt. Consult
11	All Other Consults

Preparing for Your Loved Ones Death

Death comes in its own way and time to each individual. It is a quiet and natural series of events to help the body release its spirit. Thank you for letting us share in the care of this special person during their transition time. When someone close to you is dying, it is normal to have questions about what to expect. Although sad and stressful, this can be a positive process for families to share. This booklet is designed to help you to understand what to expect at the end of life and what you can do. Please use it as a guide in addition to the support our nurses and other members of our team can offer.This information applies to patients with all types of terminal illnesses. But remember that each person is different and may not have every symptom. Our staff is available to explain the stages of dying and guide you through the experience. Please feel free to ask questions and share concerns.

Winding Down

In the final stages of life there is a gradual withdrawal from people, activities, and food. Your loved one may only have enough energy to be with one or two people. He or she may be sleepier, wishing to stay in one place and nap more. This may be due to:

- Fatigue
- The disease process
- Depression
- Medications used to control pain or restlessness
- Insomnia

Just sitting quietly beside them can be comforting. A light touch and companionable silence can speak greatly of your concern and love.

Comfort

You may wonder if the dying process will be painful. Pain, restlessness, or anxiety is possible. There are many ways to relieve pain.

Medications:

- Injections (shots)
- Medication in the vein (intravenously)
- Oral medications (by mouth)
- Suppositories
- Skin patches

Comfort measures:

- Heating pads -Changing positions
- Massage
- Special beds or mattresses - Extra pillows for support -Music
- Television
- Prayer

There may be times when your loved one will still have some pain, in spite of our attempts to relieve it. We will continue to try different combinations of methods to relieve as much pain as possible. Families are often concerned that if a patient can no longer speak we will not know they are in pain. Physical signs that may indicate pain include:

- Grimacing
- Clenched fists
- Restlessness
- Tense or rigid body
- Sweating
- Increase in breathing or heart beat - Moaning
- Insomnia

You can help by watching for these signs of pain and discussing them with your nurse.

Nutrition

Aggressive nutritional support such as IVs or tube feedings may not benefit a person who is dying. Frequently there will be more than one body system failing, causing nutrients and fluids to produce distressing symptoms. The disease process can:

- Change the desire to eat and/or the ability to digest food.
- Leave the patient with no energy or interest in eating. Therefore, it can change a pleasant experience to a distressing one.
- It is not unusual for patients to have food cravings that change from one moment to the next. They may also eat well at one meal and have no appetite for the next. It is our philosophy to allow the patient's wishes in regard to eating.

1. Families are encouraged to bring favorite foods from home (a refrigerator is available for food storage).
2. Our patient's food preferences are more important than nutritional content.
3. It is normal for a patient very close to death to refuse food completely.
   Patients who are close to death do not feel hungry or thirsty. They are not starving. Nature is at work assisting them to die in a more comfortable way.

Breathing

The patient's disease is one factor that can affect the breathing pattern. Cancer sometimes spreads to the area of the brain where the breathing control center is located. It can also affect other body systems, causing changes in breathing. The breathing pattern may become slower as well as irregular, or there may be pauses. Medication can cause slowing of breathing but this does not cause discomfort to the dying person. Breathing may become noisy and congested or labored with a rattling sound. Congestion may be caused by:

- The disease process
- Immobility
- Weakness
- Lowered resistance
- Infection

Medication, breathing treatments, oxygen, and other comfort measures such as repositioning can relieve symptoms. Suction is occasionally used but is not always helpful.

Communication

Often people wonder if the person is able to hear even though they cannot respond. Hearing is believed to be the last of the senses to go. Even when they are in a coma or deep sleep, the patient may be able to recognize familiar voices and sounds. It is good to talk to them - the sound of a familiar voice may be comforting - feel free to say whatever is in your heart.

Sometimes the dying person may need to hear you say you love them, but it is okay to leave when he or she is ready. If tears come, they are natural and a special way to say goodbye.

Touching is important. It is soothing and communicates feelings of security and love. There may be times that touching could increase pain and anxiety. During these times, just your being there may make the patient feel secure. Let the patient's reaction to touch guide you.

Spiritual and family issues may arise at this time. Our chaplains are available for spiritual care and support. Our social worker may be able to help with family and legal issues.

When Death is Near

Knowing exactly when a person will die is difficult to determine. But in many cases there are obvious signs of approaching death. These signs include:

- Changes in breathing
- Longer pauses between breaths
- Bluish color to lips, nail beds, legs
- Cool skin
- Restlessness, confusion, or speaking to unseen persons
- Muscle twitching in hands, feet, arms, and legs
- Loss of bowel or bladder control and/or decrease in the amount of urine
- Weak pulse that is difficult to detect

There are no limitations on visiting hours. If you wish to spend the night we will provide sleeping cots, blankets etc. A family lounge is available for your respite. Make coffee, which is provided, and use the refrigerator to store snacks or other supplies.

Every effort will be made to notify you when death is near. If for any reason family or friends are unable to be there, staff members will try to be at the bedside while the patient is dying. Again, every effort will be made to notify you of impending death so that you may choose to be there if you wish.

The Time After Death

You may spend as much time as you need with your loved one. Friends and family may also be present. If you need help making phone calls, we are available. The nursing staff will help you to complete any final paperwork. The person who is the Next of Kin will be needed to supply this information, either in person or by telephone.

Thank you for letting us share in the care of this special person during their transition time.

BIRMINGHAM VA MEDICAL CENTER
700 SOUTH 19th STREET BIRMINGHAM AL 35233

The Birmingham VA Medical Center wishes to thank the Clement Zabloci VA Medical Center in Milwaukee, Wisconsin for use of the material contained in this document

Birmingham VAMC Safe Harbor Project

Consider Palliative Care when patients are admitted to the hospital. This is an important aspect of care because…

Palliative Care can often assist in improving symptom control for people with pain or other physical symptoms.
The Palliative Care Team approach can assist you in relieving the emotional, social, and spiritual suffering patients may experience.
Palliative Care can help you determine the eligibility of patients for supportive care services such as Palliative Care Clinic, Home Health and Home Hospice which may provide needed assistance with home services, medications and nurse case management.
Palliative Care can help facilitate patient and family conferences to define goals of care including Advanced Directives.

Consider a Palliative Care Consult in patients with…

(Any one or more signs/symptoms)
Cancer
- Any patient with metastatic or inoperable Cancer

Heart Disease

- CHF symptoms at rest
- EF of <20%
- New dysrhythmia
- Cardiac Arrest, syncope or CVA
- Frequent ER visits for symptoms

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Pulmonary Disease

- Dyspnea at rest
- Signs or symptoms of right heart failure
- O2 sat on O2 of <88%
- P CO2 > 50
- Unintentional weight loss

Dementia

- Inability to walk
- Incontinence
- Less than 6 intelligible words
- Albumin <2.5 or decrease PO intake
- Frequent ER visits

Liver Disease

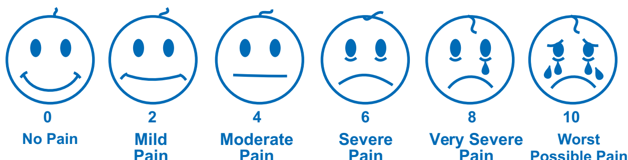
- PT> 5 Seconds
- Albumin <2.5
- Refractory Ascites
- SBP
- Jaundice
- Malnutrition and muscle wasting

Renal Disease

- Not a candidate for dialysis
- Creatinine Clearance of <15 ml/minute
- Serum Creatinine >6.0

Failure to Thrive

- Frequent ER visits
- Albumin <2.5
- Unintentional Weight loss



Best practices for
End of life care
And
Comfort care
Order sets for our
Nation's veterans

Identifying the Actively Dying Patient

When patients are admitted to the hospital and at regular intervals thereafter, it is important to screen for those who are at highest risk for end-of-life symptoms and who may be *actively dying*.

Indicators of Patients at High Risk of Entering the Actively Dying Process

1. **Pre-existing DNR order**
2. **LOS in hospital > 7 days**
3. **Bed Confinement**
4. **Semi-comatose state**
5. **Minimal oral intake (receiving IV fluids or tube feeding)**
6. **Inability or difficulty with taking oral medicine**
7. **Decline in functional status with no reversible cause**
8. **Receiving optimum disease modifying therapy (e.g. patient with COPD declining despite aggressive treatment)**
9. **Failure to improve by 2-3 days post admission**
10. **Frequent Emergency Room visits or hospitalizations over the last 6 months**
11. **Primary diagnosis of cancer or dementia**

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If one or more of the indicators is present:

1. **Review patient status for symptom burden**
2. **Discuss illness severity with patient and/or family**
3. **Determine goals of care**
4. **Document advance directives**

Actively Dying Patient Screen

1. **Audible retained respiratory secretions**
2. **Increased RR (>18-20/minute)**
3. **Sustained tachycardia at rest (>100 per minute)**
4. **Mottling and cyanosis of extremities**
5. **Decreasing level of consciousness**
6. **Decreasing pulses**

- **The Comfort Care Order Set is used to guide management of symptoms and support for patient and family.**
- **Symptom burden is often very high and not appreciated.**
- **Communication with patient and family regarding care preferences should be proactive.**
- **Patient and family will need support from an interdisciplinary team due to multiple domains of suffering.**

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Comfort Care in the Last Hours of Life

Admit to: Location and initiate Comfort Care Order Set
Diagnosis: (i.e. Metastatic Lung Cancer/Pain Crisis)
Condition: Grave
Resuscitation Preferences; Do Not Attempt to Resuscitation (DNAR) (if not, document exact status)

Diet:

Order a diet; patient may improve and desire to taste food
(Select from CPRS order set)
Full liquid instead of clear liquid (can advance if tolerated)
(Offer more palatable, easier to swallow, less likely to cause aspiration)
May have food brought in by family
Allow patient to sit up for meals; assist to eat

Activity:

Allow patient to sit in chair if desired and to use bedside commode
Allow family to stay in room with patient

Vital Signs:

Minimum frequency allowed by policy
Limit notification orders to those necessary (review options on CPRS)
Frequent monitors can alarm patient and family
Numbers can distract staff/family from patient

IV Considerations:

Placement is often difficult and painful, frequently has no benefit for patient
Presence of edema indivcates that patient is not dehydrated
Many patients have fluid overload, edema and pulmonary congestion
Oral hydration is a reasonable comprimise. (Or)
If IV fluids are used, suggest a limited time trial, such as a 1000-1500 cc D51/2 NS over 6 hours. (Select from CCOS on CPRS)

Subcutaneous (SQ) Line:

Small IV or butterfly needle inserted directly under the skin
(often on the abdoman or thigh)
For injecting small volumes of many medicines when oral route unavailable
Avoids burden of finding/maintaining IV access

Orders for Dyspnea

Oxygen 2-4 liters nasal prong; avoid face mask
Usually do not recommend monitoring oxygen saturation or telemetry
For persistent Dyspnea, use opiods
Blow air on face with bedside fan; turn, reposition, sit up. Nebs may be helpful

Hygiene

Avoid Foley catheter if possible (may be helpful for hygiene in select patients, (e.g., obese or immobilized patients)
Diapers and cleansing may accomplish same thing
Delirious patient may pull on bladder catheters
Check all patients for impaction; suppository may be helpful
Consider evaluation by skin care nurse

Pain and Dyspnea

Opioids are usually the most effective in this setting
Calculate morphine equivalents used in recent past; adjust as needed
Usually stop sustained-released medicines and use immediate release
Morphine concentrate 20mg/ml concentrate

a. Start with MS 5mg PO to much higher dose based on recent use q 2 hours, Offer, patient may refuse
b. Morphine Sulfate 2-4 subq q2 hours (1/3 the oral dose) Offer, patient may refuse
c. May use IV but shorter half/life and only RN can administer, difficulty with maintaining IV

Pain, Dyspnea, Anorexia, Asthenia & Depression

Dexamethasone 4-8mg PO/SubQ breakfast and lunch
Corticosteroids can have multiple beneficial effects
Less mineral-corticoid effect than Prednisone
Does not have to be given in multiple doses

Nausea and Delirium *(Phenothiazines)*

a. Haloperidol 2mg PO or 1mg Subq Q 2 hours, X3 doses total or until settled then q 6-8 hours PRN
b. Patient > 65 years of age
Haloperidol 1mg PO or 0.5mg Subq Q 2 hours, X3 doses total or until settled. Nausea usually requires less frequent doses

Anxiety and Seizures *(Benzodiazepines)*

a. Lorazepam 1mg PO/SubQ q6-8 hours prn
b. Patients >65 years of age Lorazepam 0.5mg 1mg PO/SubQ Q 6-8 hours prn

May be helpful with anxiety
Exercise care as delirium can sometimes be mistaken for anxiety
Effective against seizures only as IV or SQ and not PO

Death Rattle

a. Keep back of throat dry by turning head to side
b. Stop IV fluids or tube feeding,
c. Use Scopolamine patch topical behind ear q3 days
d. Use Atropine eye drops 2-3 in mouth q4 hours or until patch effective
e. Avoid deep suctioning
f. Family can cleanse with sponge sticks

Tips for Comfort and Safety

Reposition, massage, quietly sit with and speak to patient
Avoid sensory overload (e.g., TV) soft music instead
Use bed minder in leiu of restraints to alarm if patient gets up

Assisting Family

Advise about alerting other family members as to gravity of patient's status
Facilitate family presence; order permission for family to visit or stay
Arrange visits of military relatives by contacting Red Cross
Arrange visits of incarcerated relatives by contacting warden
Give family the pamphlet *Preparing for Your Loved One's Death.*

Notify Pastoral Care and Social Work of admission
Avoid restraints

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OPIOID EQUIANALGESIC CONVERSION TABLE

(Dosing in mg unless listed)

ORAL	OPIOID AGENT	IV/IM/SQ
30	Morphine (MSC, OSR, Roxanol ™)	10
8	Hydromorphone (Dilaudid™)	2
20	Methadone(Dolophine™)	--
300	Meperidine (Demerol™)	100
30	Oxycodone (Roxicodone™, OxyContin™)	--
4 tabs	Oxycodone 5mg/APAP 325mg (Percocet™)	--
6 tabs	Hydrocodone 5mg/APAP 500mg (Lortab5™)	--
6 tabs	Codeine 30mg/APAP (Tylenol #3™)	--
200+	Codeine	--

FENTANYL PATCH CONVERSION

25mcg/hour topically exchanged every 72 hours
Is equivalent to the following:
Morphine 15mg IV or 45mg PO per day
Hydromorphone 3mg IV or 12mg PO per day
Percocet ™/ Lortab5 /Tylenol #3 ™ - 9 tabs per day

PCA Dosing

Usual Initial PCA Dosing

Morphine 1-2mg (10mg/ml)
Hydromorphone 0.25mg-.5mg (0.5mg/ml)

- INTERVAL LOCK-OUT: every 10-15 minutes
- FOUR HOUR LIMIT: none

1. After 24-48 hours of consistent PCA use for chronic pain, Continuous Hourly Infusion Rate may be set at 50-75% of the daily PCA use. If a Continuous Hourly Infusion Rate is initiated, the PCA Dose should be adjusted to 50-100% of this Continuous Hourly Infusion Rate every 10-15 minutes based on patient's response.
2. Decrease the Continuous Hourly Rate as PCA use declines to avoid overmedication.
3. Never use a Continuous Rate in acute pain of a limited nature.

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- Dosing tables only provide conversion estimates. Patient response may differ. Consider partial cross-tolerance when rotating to a new opioid. A well-controlled patient may require a 25% or greater dose reduction of the newly chosen agent. Opiate agonists have different durations of action, extent of oral absorption, and elimination, which may affect patient response.

- Methadone has a longer elimination half-life than duration of action and may require dose adjustment to prevent over accumulation.

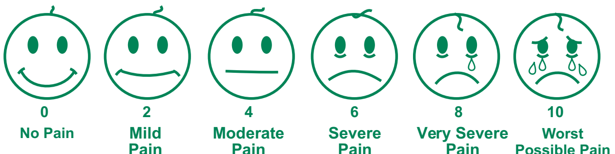
- Meperidine is not indicated for prolonged therapy (greater than five days) and Normeperidine (a metabolite) may lead to seizures in patient with decreased renal function. Oral absorption of Meperidine is less reliable than other opiates and is not recommended. Its absorption, elimination, and toxicity can be affected by many drug interactions that inhibit or enhance its metabolism.

- The daily dose of acetaminophen (Tylenol) should not exceed 4 grams in a 24-hour period. This means that patients can not use more that 8 Lortab or Tylox tablets, or 12 Percocet tablets in a 24-hour period without exceeding this limit. If pain can not be controlled with this number of tablets, opioids not in combination with acetaminophen should be used.

- Darvon and Darvocet are ineffective analgesics, and their use is discouraged.

- Constipation secondary to opioids is common. A large bowel stimulant such as Senna or Dulcolax should be prescribed in conjunction with opioids.

- Oxycontin should not be prescribed at less than a 12-hour interval. MsContin and Oramorp should not be prescribed at less than an 8-hour interval.



The Palliative Response ~ Sharing Bad News

1 The First Step in Planning Care

- Develop therapeutic relationship
- Discuss patient/family agenda first
- Allow physicians' priorities to flow naturally from patient/ family (e.g. discussion of resuscitation and other advanced directives)

2 Discussion Agenda

- Physical Care - Setting and level of residential care
- Social Care - Family issues (e.g. dependence)
Financial issues (e.g. disability)
- Emotional Care - Sources of support
- Spiritual Care - Sources of meaning

3 Physician Role and Preparation

- DO NOT DELEGATE sharing bad news!
- Sharing bad news is physician's role
- Patients often accept bad news from MD only
- MD is best prepared to interpret news and offer advice
- Confirm medical facts
- Plan presentation with one or two main points only
- Use simple, lay language

4 Setting the Stage

- Choose appropriate, private environment (hallway/curtain do not provide privacy)
- Have tissue available
- Allot enough time (20-30 minutes minimum with documentation)
- Determine who should be present
- Turn beeper to vibrate to avoid interruptions and demonstrate full attention
- Shake hands with the patient first
- Introduce yourself to everyone in the room
- Always sit at eye level with patient, distance of 50-75 cm
- Ask permission before sitting on edge of bed
- Arrange seating for everyone present if possible so that patient is at ease and not concerned about others' comfort

5 Starting the Conversation

- ASK: What does patient/family understand about what is happening? What have others told them?
- WAIT: 15-30 seconds to give opportunity for response
- LISTEN: Response may vary from “I think I am dying,” to “I don't understand what is happening.”
- ASK: How much that patient wants to know? Does patient want to know prognosis? (Patient may decline voluntarily and designate another person as spokesperson)

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The Palliative Response ~ Sharing Bad News

6 When Family Wants to "Protect" Patient

- Honor patient's autonomy
- Meet legal obligation for consent
- Promote family alliance and support for the patient
- Ask what family is afraid will happen
- Offer to have family present when you speak to patient so family members can hear patient's wishes about knowing status/prognosis

7 Sharing Bad News

- Give a warning to allow people to prepare
- Briefly state one or two key points only
- Use simple language

+ STOP +

- Ask questions to assess understanding
- Address key considerations
- Do not minimize severity of news
- Recommended statement for terminal illness:
- "This is an illness that man cannot cure."
- Statement shows medical humility, leaves open possibility of the miraculous, and helps shift focus from "cure" to Palliation and Support

8 Response to Emotions of Patient, Family and Staff

- Be prepared for a range of emotions
- Address key components of response
- Allow time for response
- Communicate nonverbally as well as verbally- it is usually acceptable to touch patient's ARM

9 Suggest a Brief Plan

- Medical Plan (e.g. control dyspnea, home assistance to help deal with weakness)
- Ancillary Support (e.g. social work visits, pastoral care visits)
- Introduce Advance Care Planning
  "Sometimes when people die, doctors try to bring them back to life . . . have you considered whether or not you want this?"
- Discuss Timeline

10 Offer Follow-up Meeting

- When? Usually within 24 hours
- Who? For current and additional family members
- Why? To repeat portions of the news
- How? Offer to contact absent family members
  Get permission to share news if necessary
- What? Next meeting, upcoming decisions, suggest flexible timetable

11 Ending the Meeting

- ASK "Do you have any questions?
- WAIT
- ANSWER
- STAND an effective way to end the conversation

The Palliative Response
Guidelines for Pronouncement

Preparation before Death Pronouncement

Be prepared to answer pertinent questions
Nursing staff can provide wealth of information
Know recent events, family response and dynamics, and special problems or concerns

Assess Immediate Situation

- Death expected or sudden?
- Family present or notified?
- Attending notified?
- Autopsy
  - Determine family preference
  - Consider value of autopsy
- Organ Donation
  - If family requests, contact organ donation counselor to discuss details
- Faith Tradition
  - Consider Pastoral Care contacts
  - Honor requirements/procedures/rituals

Entering the Room

Assume quiet, respectful attitude
Ask nurse to accompany for introductions
Introduce yourself and role: ***"I am the doctor on call"***
Determine relationships of persons present
Inform family of purpose; invite to them to remain
Empathize simply:
"I am sorry for your loss; this is a difficult time"

Pronouncement Procedure Clinical Examination

Check ID bracelet and pulse
Check pupils for position and response to light
Check response to tactile stimuli
  Examine respectfully:
  No Sternal Rubs or Nipple Pinches
Check for spontaneous respiration
Check for heart sound and pulses
Record time of death

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Follow-Up

When You Are Patient's Physician

Invite family to contact you over the next few days, weeks, or months if questions arise or problems occur

When You Are Physician on Call

Assure family you will report death to the attending physician, whom they may contact with questions or concerns

Death Note in Chart

- **Document date and time**
- **Document name of provider pronouncing death**
- **Provide brief statement of cause of death**
- **Note absence of pulse, respiration, pupil response**
- **Note if family present or informed**
- **Note family response if indicated**
- **Note notification of attending, pastoral care, social work or others as appropriate**

Death Certificate

Locate sample Death Certificate on unit
Complete marked sections. Write neatly in black ink.
Begin again if make an error (cross-outs not allowed)

Document cause of death -

Primary cause of death - Example - Pneumonia

Secondary cause of death - Example - Advanced Alzheimer's Dementia

Contributing cause of death - Example - Agent Orange, Asbestosis. List other illnesses possibly linked to patient's disability or service-connection

Documentation assists family to obtain benefits
Families appreciate and respond to a respectful and kind approach to this final medical act

If families should contact you later

- Take time
- Inquire about family members
- Listen carefully
- Respond empathically

Death Pronouncement is the Final Medical Act
Handle with Care