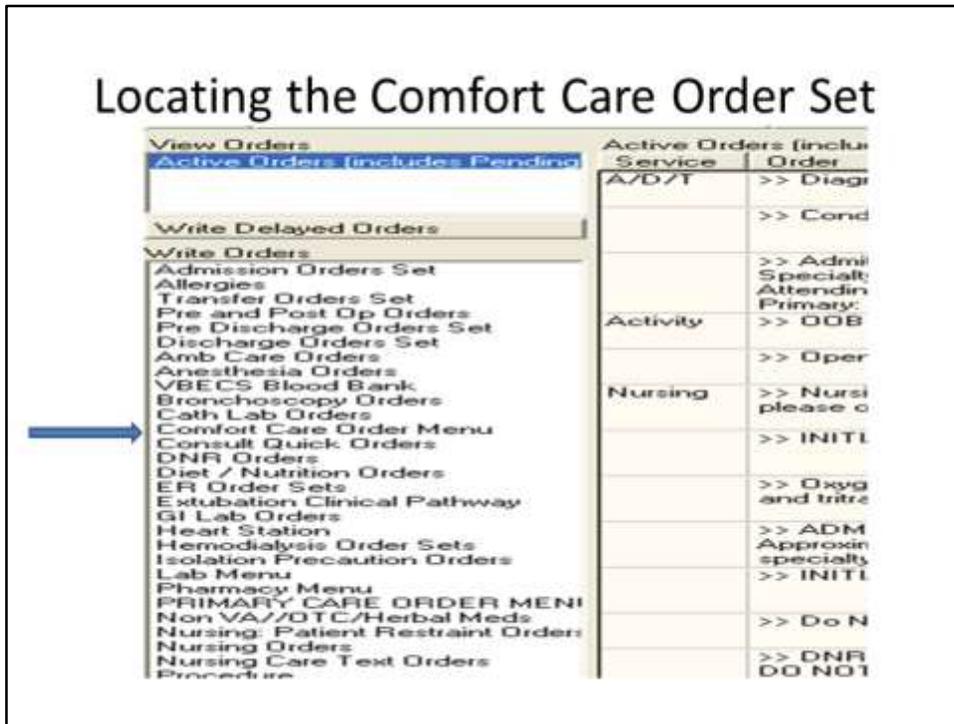


# Comfort Care Order Set

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## Locating the Comfort Care Order Set



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

From this location you could

- 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.

View Orders		Active Orders (includes Pending & Recent Activity)	
Active Orders Includes Pending		Service	Order
		A/D/T	>> Diagnosis : Pain Crisis
			>> Condition : POOR .
			>> Admit to Hospice for Acute Care Specialty: HOSPICE FOR ACUTE CA Attending: LEIGH,ALEXANDRA E Primary: LEIGH,ALEXANDRA E
		Activity	>> OOB to chair BID and preferably ot
			>> Open curtain during day.
		Nursing	>> Nursing Care: please order Pegasus air mattress .

**Write Orders**

- Admission Orders Set
- Allergies
- Transfer Orders Set
- Pre and Post Op Orders
- Pre Discharge Orders Set
- Discharge Orders Set
- Amb Care Orders
- Anesthesia Orders
- VBECS Blood Bank
- Bronchoscopy Orders
- Cath Lab 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) that is a location different from the current one.

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

The next slide will demonstrate the Delayed Order Writing Option.

# Writing Delayed Transfer Order

Use Transfer: if inpatient will move from one ward to

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

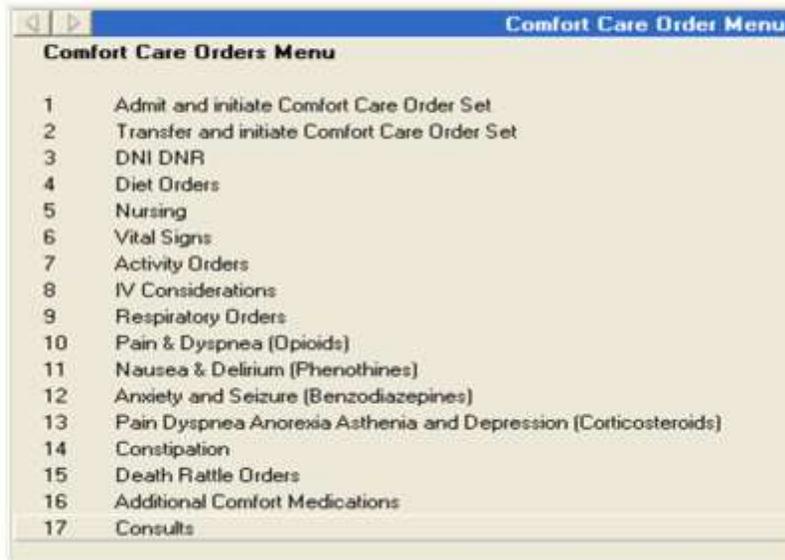
Admit to Blind Rehab
Admit to Cardiac Surgery
Admit to Cardiovascular Surgery
Admit to E.N.T.
Admit to General Medicine
Admit to General Surgery
Admit to Gynecology
Admit to Head & Neck Surgery
Admit to Hospice for Acute Care
Admit to Medical I.C.U./C.C.U.
Admit to Neurology
Admit to Neurosurgery
Admit 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. Please note that you may be changing the bed section designation but not changing the location of the bed geographically. In that case you do have to enter new orders and using the Delayed Orders is the best option to do this without having the patient have a break in orders that could cause poor symptom control.

# Comfort Care Order Set

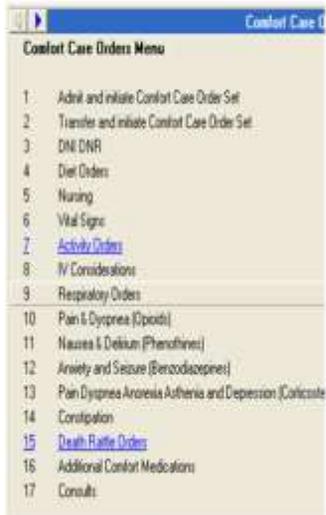


This is the appearance of the Comfort Care Order Set when you select the option in the "Write Orders" tab. At this point you could start at the top and work your way through the list. It is recommended that a provider work through all of the sections a few times to become familiar with the CCOS. After 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 other symptoms preemptively, so that if the patient develops delirium 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 the CCOS and reopen it.

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: [dropdown]

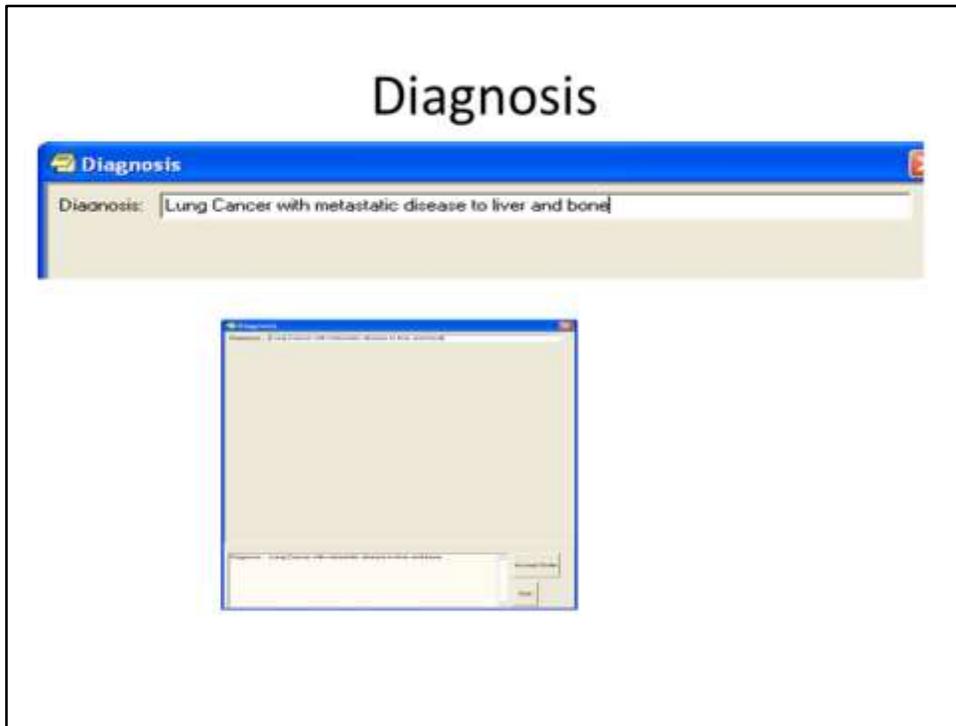
Start: HOSPICE FOR ACUTE CARE GENERAL MEDICINE

If you are admitting a patient to the VAMC and desire to use the CCOS you select the Admission 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 since we do have a mixed unit with some patients in an Acute Care for the Elderly Track with the General Medicine Bed section.

# Diagnosis



## Diagnosis

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

# Condition

The image displays two screenshots of a software interface titled "Patient's Condition".

The top screenshot shows the form with the following fields:

- Order:** A dropdown menu with "CONDITION" selected.
- Enter condition:** A text input field.
- Start:** A date selection field.
- Stop:** A date selection field.

The bottom screenshot shows the same form with a list of condition options displayed below the "Start" and "Stop" fields:

- CRITICAL
- FAIR
- GOOD
- POOR
- SERIOUSLY ILL
- GRAVE

At the bottom of the form, there is a "Save" button and a "Cancel" button.

## Condition

This is also an administrative requirement to be declared at admission. This option has a pull down 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

The screenshot shows a software window titled "Transfer & Initiate Comfort Care Order Set". The form contains the following fields:

- Order: TRANSFER & INITIATE COMFORT
- Date/time for transfer: Jul 30, 2010@12:00
- Required Statement: I have discussed the transfer of this patient with the following Attending Physician who has completely concurred with this action.
- Attending physician: BAILEY, F AMOS
- Transfer patient to: (empty field)
- Stop: HOSPICE FOR ACUTE CARE GENERAL MEDICINE

Below the main form is a smaller, partially obscured window showing a list of options, likely for selecting a bed section.

## 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 prompt as noted on the previous example for an admission.

# Designation of Resuscitation Status

The image shows two overlapping software windows. The background window is titled 'DNR Orders' and contains a list of order types: '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)', and 'REMOVE DNR (REMOVES DNR POSTING FROM COVER SHEET)'. The foreground window is titled 'Patient Care Order' and has a 'Patient Care' dropdown menu set to 'DNR'. Below this is a text field containing 'DO NOT ATTEMPT RESUSCITATION'. There are also fields for 'Start Date/Time' and 'Stop Date/Time', and a 'DNR DO NOT ATTEMPT RESUSCITATION' checkbox with an 'Accept Order' button and a 'Go' button at the bottom right.

## 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.

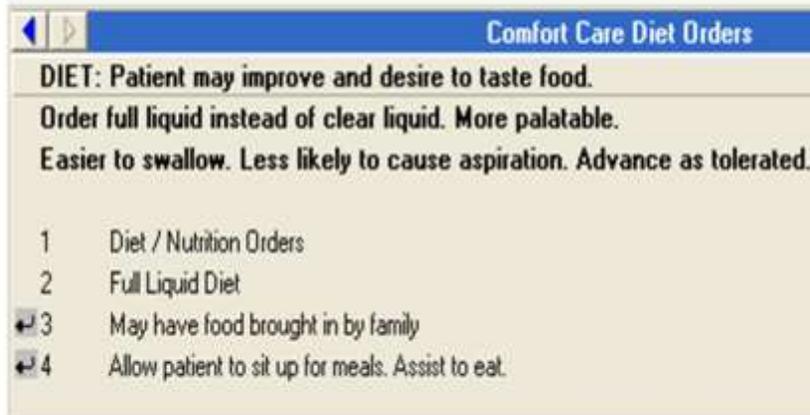
## Additional Notes

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



## 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 and this is frequently not necessary and causes distress to patient and family. The default diet that is recommended is the Full Liquid Diet since 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.

It is recommended that the order "May have food brought in by family" and "Allow patient to sit up to eat. Assist with meals" be placed. Patients are not supposed to eat food other than that provided by the facility unless there is an order and families may need prompting and assistance to learn to help their family member sip or eat safely if they desire food.

# Diet Orders



## 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	30	NPO Order (specify date/time)
3	Order 2000 ADA Diet	31	NPO w/ MIDNIGHT Tonight
#4	Order CHEMO Diet	32	NPO NOW Order
5	Order CLEAR LIQUID Diet	#33	NPO Except Ice Chips
6	Order DENTAL Diet		
7	Order FULL LIQUID Diet		
8	Order MODIFIED CLEAR LIQ Diet		
9	Order PRUDENT Diet		
10	Order PURÉE Diet		
#11	Order 25m NA Diet		
#12	Order 45m NA Diet		
			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 that they can choose from all the options that the particular facility offers.

# Sample Nursing Orders

Conduct 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 vitals 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 amplifiers for HDH 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 implement care plans for environmental modification for specific issues, such as care of the actively dying patient or for delirium.

This is the menu

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 HDH 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 for comfort.

If there is an arrow for this then the order can go in directly to the order sheet. If not, a dialog box will come up that may require some 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

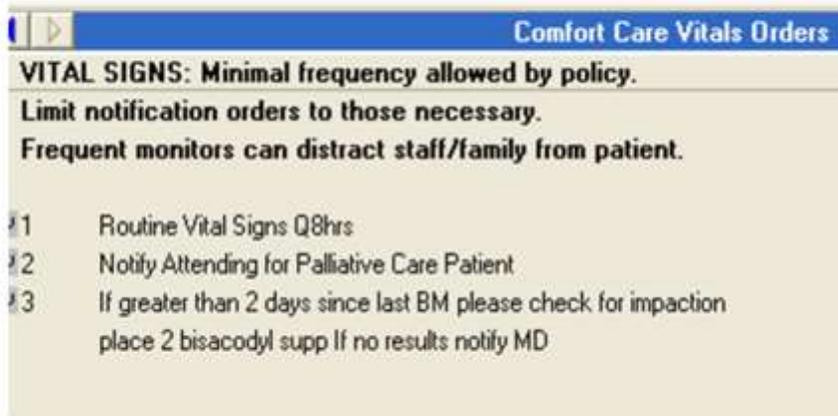
#### Avoid Restraints

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

Assisting Family is decision support to help remind the 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 a pamphlet that describes the dying process for family education. This can be provided to families and the clinicians can review with family 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 and 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 decision to stop doing vital signs is made then this could be ordered instead.

See notification on the next page

Also an opportunity to assess constipation. Daily review of bowel regiment effectiveness by noting of BM in last 24-48 hours help reduce painful constipation or obstipation.

# Notifications

The screenshot shows a window titled "Notify MD" with a blue header and a close button. The main area contains several fields for notification details:

- 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

At the bottom, there is a summary of the notification and two buttons: "Accept Order" and "Quit".

These notifications 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

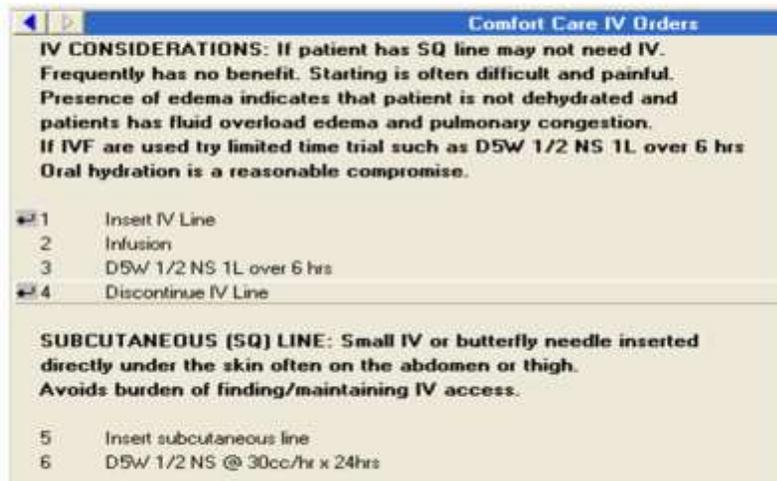
Family present and need to speak with clinician

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

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



# IV Considerations



**Comfort Care IV Orders**

**IV CONSIDERATIONS:** If patient has SQ line may not need IV.  
Frequently has no benefit. Starting is often difficult and painful.  
Presence of edema indicates that patient is not dehydrated and patients has fluid overload edema and pulmonary congestion.  
If IVF are used try limited time trial such as D5W 1/2 NS 1L over 6 hrs  
Oral hydration is a reasonable compromise.

- 1 Insert IV Line
- 2 Infusion
- 3 D5W 1/2 NS 1L over 6 hrs
- 4 Discontinue IV 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

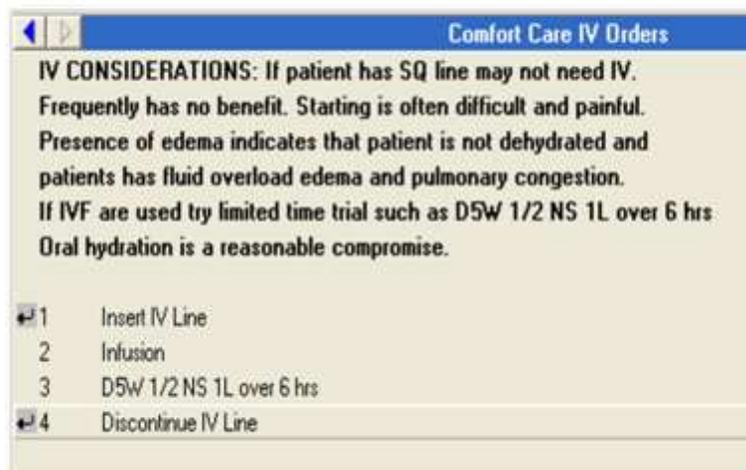
IV fluids at end-of-life in the hospital can be both beneficial but also burdensome for patients. Patients on home hospice programs do not commonly receive IV Fluids. However, in the hospital they are potent symbols of care and “doing something”. For some patients hydration with IVF may be helpful to 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 treatment such as a blood transfusion, that may be helpful in palliation of specific symptoms.

However, IV access is often difficult to maintain, which leads to patient discomfort due to multiple attempts to start an IV. There is also significant risk of line associated infection. In addition many patients may have IVF infusing in the last few days of life and this contributes to edema and fluid overload which is distressing in and of itself.

Patients on maintenance IVF are also tethered by this line and may be restrained to protect the line.

Most medications for comfort can be given through a subcutaneous line which is easy to place and maintain, is not painful, has low risk of infection. Medication that can be administered 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



Please 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 , position or struggling to prevent the line from being dislodged .

If you want to choose a different fluid 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 since there is a risk of infection. Also in many facilities IV's 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 SC opioids since the length of effect of the opioid 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 SC line if a continuous infusion is needed and the second for the intermittently administered medication.

Hyperdermoclysis is the infusion of fluid with a SC line. Please see the next page for more details.

# Hyperdermoclysis

The screenshot shows a software interface for creating an infusion order. The window is titled "Infusion Order". It features a list of solutions on the left, including 0.225% NaCl, 0.45% NaCl/5% Dextrose, 0.9% NaCl, and 10% Dextrose. The selected solution is "DEXTROSE 5%/SODIUM CHLORIDE 0.45% INJ.SOLN" with a volume of 500 ML. The route is set to "SUBCUTANEOUS" and the type is "Continuous". The infusion rate is 50 ml/hr, and the duration is 720 ml. A comment is entered: "Infuse 30cc/hr x 24 hrs (continuous), SQ line fluid trial order for palliative care patient". The interface includes "Accept Order" and "Quit" buttons.

## 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 in a hospice or palliative care patient .

The default is for a lower 30 or 50 cc per hour infusion. As mentioned earlier IVF are potent symbols of care and caring. Some families even after discussion and teaching may feel uncomfortable with stopping IVF 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 hyperdermoclysis may meet the families need for symbolic care and reduce the burden of the therapy on the patient.

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

In the appendix for this manual, an example of policy and procedures for subcutaneous line placement and for subcutaneous medicine administration and hyperdermoclysis is provided.

# Respiratory Therapy

The screenshot shows a window titled "Comfort Care Respiratory Orders" with the following text:

**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

## 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 may wear the oxygen for part of the time but also use environmental modifications such as using 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, auto-peep and 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 MV. 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 environmental modifications described above are often not utilized, not available and/ or patients are prevented from modifying their personal environment for their comfort.

# Oxygen Nasal Cannula

The screenshot shows a software window titled "Oxygen Nasal Cannula at". It contains the following fields and controls:

- Orderable Item:** A dropdown menu with "OXYGEN NASAL CANNULA" selected.
- Specific flow rate (L/min):** A text input field containing "2 L/m".
- Start:** A dropdown menu with "NOW" selected and a "..." button.
- Stop:** A dropdown menu with "t+30" selected and a "..." button.
- Summary:** A text box at the bottom left containing "OXYGEN NASAL CANNULA at flow rate of 2 L/m, add humidity and titrate to comfort".
- Buttons:** "Accept Order" and "Quit" buttons are located at the bottom right.

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 corrections 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 some evidence from studies indicate that air moving over the airways may relieve dyspnea in some patients as effectively as oxygen.

However, many patients at end-of-life do not tolerate an oxygen mask as it makes them feel smothered even if it does in part correct the hypoxia. If the mask or more intrusive oxygen therapy such as BiPAP or CPAP is a bridge to a time of recovery then 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 bedside to blow air on patient for comfort.

# Albuterol Nebulization

The screenshot shows a 'Medication Order' window for 'ALBUTEROL 0.5% SOLN FOR INHAL UD SOLN,INHL'. The interface includes a table for dosage and schedule, a comments field, and administrative options.

Dosage	Complex	Route	Schedule (Day-Of/Week)	PRN
2.5MG 0.5%		INHALATION	Q4HR	<input type="checkbox"/>
			Q1HR	<input type="checkbox"/>
			Q24HR	<input type="checkbox"/>
			Q2HR	<input type="checkbox"/>
			Q-2WEEKS	<input type="checkbox"/>
			Q30 MINS	<input type="checkbox"/>
			Q3D	<input type="checkbox"/>
			Q3HR	<input type="checkbox"/>
			Q-3WEEKS	<input type="checkbox"/>
			Q48HR	<input type="checkbox"/>
			Q5MIN	<input type="checkbox"/>
			Q-4WEEKS	<input type="checkbox"/>
			Q5MIN	<input type="checkbox"/>
			Q6HR	<input type="checkbox"/>
			Q72HR	<input type="checkbox"/>
			Q8HR	<input type="checkbox"/>
			Q96H	<input type="checkbox"/>

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 (30/8000)

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

Buttons: 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 their illness. Many patients also report subjective benefit from A/A nebulization, particularly if they are too weak to be able to effectively use the MDI. 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 find anxiety associated with the albuterol treatment.

The orders are set at default of Q4 hours but note that they are while awake. 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.

Please see the next slide for the ipratropium order.



# Respiratory Therapy Menu

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

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

# Opioid for Pain and Dyspnea

Comfort Care Opioid Orders	
<b>PAIN AND DYSPNEA (OPIOIDS): Opioids usually most effective.</b>	
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
<b>CONSTIPATION: Initiate if on opioids or no BM x 2 days.</b>	
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

Since pain and dyspnea are such common symptoms at the end-of-life this section is critical and all patients should have some medications from this panel selected to ensure that patients 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 dark and bold section is the decision support to guide the clinician in choosing treatment options listed below. Common barriers to adequate opioids for patient at end-of-life include route, patients not able to swallow pill or tablet and needing sublingual or parental route. A second problem is that patients are weak and not able to request PRN medication so having scheduled “offer may refuse” or “based on symptoms” helps. 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 and 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 so were for practical purposes opioid naïve. These orders should be seen as a dose finding for the next 12-24 hours and will provide guidance on choosing effective dosing regimen for those 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 then it would be appropriate to choose this.

# Morphine Concentrate

Medication Order
Change

MORPHINE SULFATE CONCENTRATED SOLN.CONC

**CONCENTRATED**

Dosage	Complex	Route	Schedule (Day-Of-Week)
5MG/0.25ML		SUBLINGUAL	Q2HR
5MG/0.25ML	0.020075	NG TUBE/ORAL	PC
10MG/0.5ML	0.06015	TOPICAL	Q MONTH
20MG/1ML	0.1203	ORAL	Q10MIN
30MG/1.5ML	0.18045	SUBLINGUAL	Q12HR
40MG/2ML	0.2406		Q15MIN
			Q18H
			Q1HR
			Q24HR
			<b>Q2HR</b>
			Q-2WEEKS
			Q-30 MINS
			Q3D
			Q3HR
			Q-3WEEKS
			Q48HR
			Q4HR

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

Give additional dose now

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.

Priority  
ROUTINE

Accept Order  
Quit

## General Review of opioid orders:

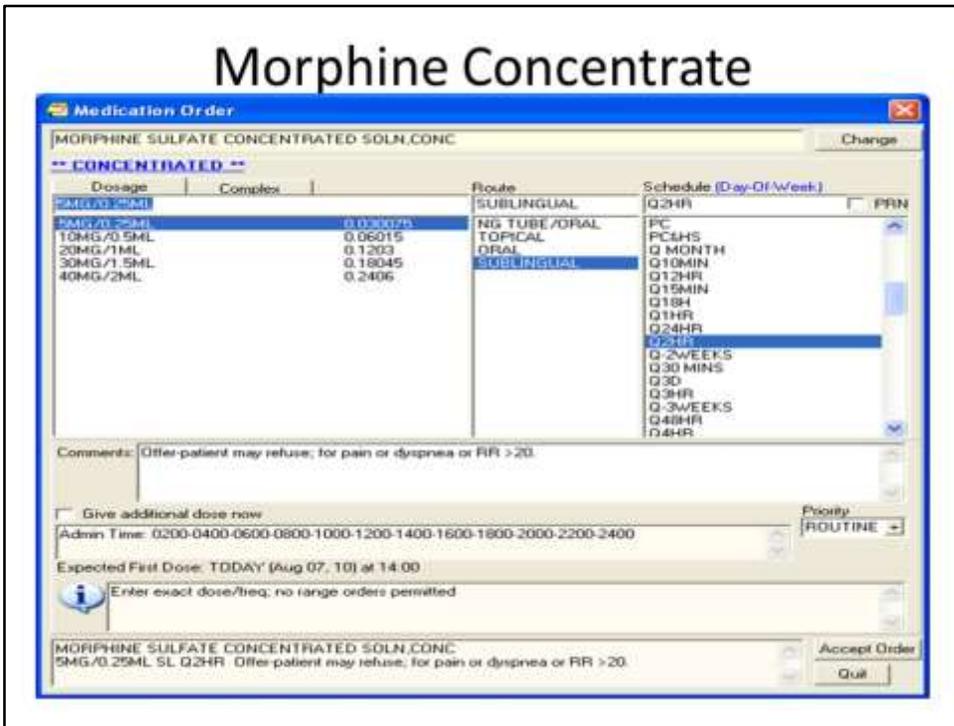
Default is set to lower doses, such as in this case, morphine 5mg SL. The provider does have the option to choose a higher dose.

These medications are scheduled q 2 hours. This may seem frequent but they are meant 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.

Also 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 every 2 hours if the pain medication is needed. If the patient can respond at all the staff member could offer with the patient being able to decline, for non-verbal patients the staff should use the non-verbal pain assessment and clinical judgment or if the patient has a respiratory rate of greater than 20/ minute this could be indication of dyspnea that could benefit from opioids.

This is actually easier for nursing staff documentation 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 is given and does not have to do double documentation.

# Morphine Concentrate



## Morphine Concentrate

Morphine Concentrate is 20mg/ml and can be administered sublingual. 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 at home there has been some barriers to use in the VA inpatient setting. In general, there seems to be a preference for parental medications, IV/SQ, among both physicians, nursing and patient and families as this is perceived as more “effective” and also more inline with culture of using injections or parental medications. We have seen that the SQ options is commonly used in many of the hospitals where this CCOS has been implemented.

Another barrier is pharmacy and 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 MS concentrate up in Insulin syringes so that there is a unit dose. Other have purchased unit doses that come in 1 ml ampules that have 20mg of MS and this often leads to needing to waste a medication each time the ampules are opened.

# Morphine Solution

The screenshot shows a 'Medication Order' window for 'MORPHINE SULFATE SOLN. ORAL'. The window is divided into several sections:

- Table:** A table with columns for 'Dosage', 'Complex', 'Route', and 'Schedule (Day-Of-Week)'. The 'Route' column is currently set to 'ORAL', and the 'Schedule' column is set to 'Q2HR'. A dropdown menu is open, showing various scheduling options like 'PC', 'PC&HS', 'Q MONTH', etc.
- Comments:** A text box containing the comment: 'Offer-patient may refuse; for pain or dyspnea or RR >20.'
- Admin Time:** A dropdown menu showing time intervals from 0200-0400 to 2000-2200-2400.
- Priority:** A dropdown menu currently set to 'ROUTINE'.
- Buttons:** 'Accept Order' and 'Quit' buttons are located at the bottom right.

Dosage	Complex	Route	Schedule (Day-Of-Week)
5MG/2.5ML	0.1965	ORAL	Q2HR
10MG/5ML	0.393	ORAL	PC
15MG/7.5ML	0.5895	ORAL	PC&HS
20MG/10ML	0.786	ORAL	Q MONTH
30MG/15ML	1.179	ORAL	Q10MIN

## Morphine solution

Morphine solution is a 10mg/5ml concentration which may make it easier to administer in some patient populations. 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 concentration and flush the tube than to try to administer the more concentrated and very small volume of the MS concentrate.

The orders regarding dose, timing and scheduling is 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	Route	Schedule (Day/Of/Week)	PRN
2MG/1ML		SUBCUTANEOUS	Q2HR	
3MG/1ML	0.226	IV PUSH	PC	
4MG/1ML	0.692	INTRAMUSCULAR	PC&HS	
8MG/1ML	1.345	INTRAVENOUS	Q MONTH	
10MG/1ML	0.775	NASAL	Q10MIN	
15MG/1ML	0.135		Q12HR	
15MG/1ML	0.1095		Q15MIN	
20MG/2ML	1.55		Q1HR	
30MG/2ML	0.219		Q24HR	
			Q2HR	
			Q-2WEEKS	
			Q30 MINS	
			Q30	
			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 RR >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 parental morphine.

It should be noted that morphine IV is not recommended routinely in the CCOS. Problems encountered with morphine IV include: a) short half life of 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 going to be used IV it is best administered as a Patient Control 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 and c) the pain and distress of maintaining and restarting IV lines in patients at the end-of-life.

For these reasons SQ administration is recommended 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 Pump Basal/PCA

Medication Order

MORPHINE SULFATE PCA INJ
Change

Dosage	Complex	Route	Schedule (Day-Of-Week)	PRN
1MG/1ML		SELECT AN EQUIV		<input checked="" type="checkbox"/>
1MG/1ML	4.7616	INTRAVENOUS	5QD	
2MG/2ML	9.5232	INTRAVENOUS	AC	
5MG/1ML	5.921	INTRAMUSCULAR	AC&HS	
10MG/2ML	11.842	NASAL	BID	
		SELECT AN EQUIV		
			BID (0600-1200)	
			BID (ANTI-DIABETIC)	
			BID (NITRATES)	
			BID (WITH MEALS)	
			DAILY	
			EVERY OTHER DAY	
			FR	
			HS	
			MD	
			MD-FR	
			MD-TU/WE	
			MD-WE-FR	
			NOW	

Comments: Offer-patient may refuse; for pain or dyspnea or RR >20. Give 1mg Q15min  
 IV via PCA Pump.  
 Basal rate: \_\_\_\_\_ mg/hr  
 PCA: \_\_\_\_\_ mg/\_\_\_\_\_ min

Give additional dose now

Priority: ROUTINE

Enter exact dose/freq; no range orders permitted

MORPHINE SULFATE PCA INJ  
 1MG/1ML SC PRN Offer-patient may refuse; for pain or dyspnea or RR >20. Give 1mg Q15min  
 IV via PCA Pump.

Accept Order  
Quit

### Morphine PCA

This is set as a default and prompts for ordering a basal rate and the PCA function.

For relatively opioid naïve patients able to use the PCA function you could set the PCA and then after 8-12 hours use the number of demands and dose given as a guide to set a basal rate.

For patients who have been on oral opioids and are not able to continue taking the oral medications please 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 will need a higher dose.

Also note that if a patient is not able to use PCA function and basal dose is set that you can use the previous MS 2 mg (or higher dose if needed) q 2hour offer may refuse as the breakthrough for the pump.

## Morphine Infusing for Higher Concentration

Medication Order
Change

MORPHINE HOSPICE INFUSION INJ Change

Dosage	Complex	Route	Schedule (Day-Of-Week)
10MG/1ML		SUBCUTANEOUS	<input checked="" type="checkbox"/> PRN
10MG/1ML		SUBCUTANEOUS	SC-D AC AC/HS BID BID (0900-1200) BID (ANTI-DIABETIC) BID (NITRATES) BID (WITH-MEALS) DAILY EVERY OTHER DAY FR HS HO MO-FR MO-TU-WE MO-WE-FR NTW

Comments: SUBCUTANEOUS INFUSION RATE: \_\_\_\_\_

Give additional dose now Priority: ROUTINE

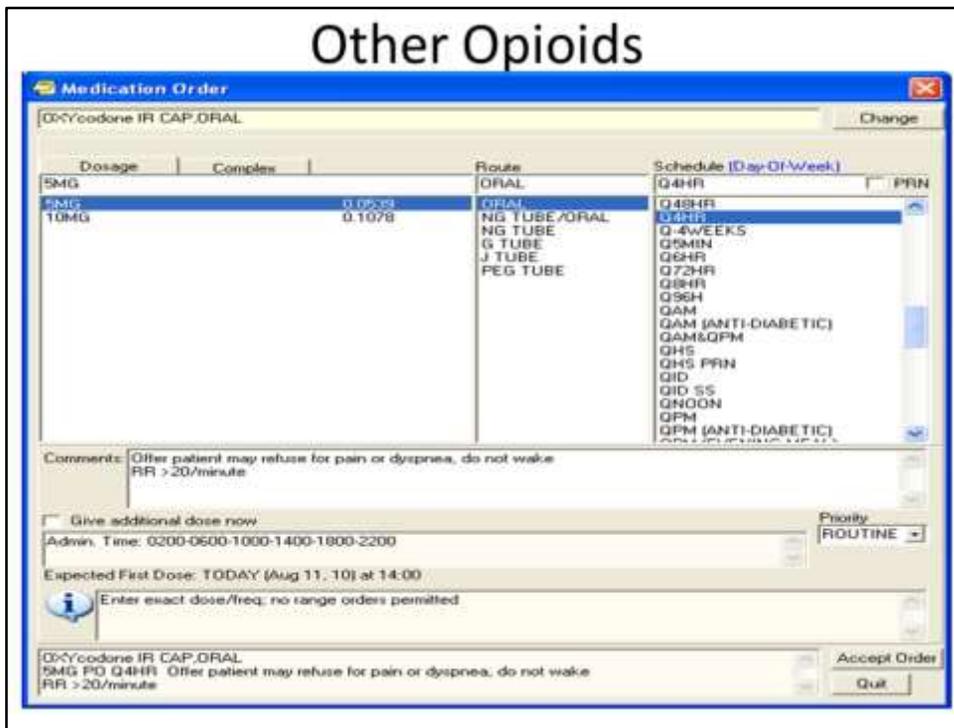
i CONC: 10MG/ML

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 hours. For many standard PCA pumps the syringes only contains 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 be more easily ambulatory if they are able to get up.

The experience of the teams using the CCOS is that this modality is needed for a small number of patients but can be very helpful to control pain and improve quality of life for that select group.



### Other Opioids

For hospice and palliative medicine clinicians there are a number of other opioid medications that are helpful and may be preferred in individual patients.

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 in patients as they decline and are no longer able to swallow tablets. It would be 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 both intermittently or as part of a PCA pump. This is a much more potent medication and an experienced palliative care team should supervise therapy.

**Fentanyl Patch:** This may be appropriate but should be prescribed only after a dose finding is completed. Would recommend supervision by experienced providers.

# Linking Laxative Therapy to Opioid Therapy

**Central Care Opioid Orders**

**PAIN AND DYSPNEA (OPIODS):** Opioids usually most effective. Calculate morphine equivalents used in recent past adjust a SL q2h after patient may refuse. PO meds offer longer duration of action than IV/subQ. Morphine PO to IV equivalent is 3:1.

- 1 Morphine 5mg SL Q2h
- 2 Morphine 5mg PO Q2h
- 3 Morphine 2mg SQ Q2h
- 4 Morphine 1mg IV PCA Pump per Protocol
- 5 Morphine 50mg NS 50ml SQ Intubation
- 6 DepoDur

**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 MDM 30ml PO DAILY PRN constipation
- 12 Lactulose 30gm/45ml DAILY
- 13 Bisacodyl SUPP 10MG PR DAILY PRN
- 14 FLeets enema PR DAILY PRN

## Constipation

This section for constipation appears in the CCOS as its own section. If choices for laxatives have already been chosen when an opioid was ordered, the clinician may skip this section. This is placed here because it is important that a bowel regiment always be ordered when patients are prescribed opioids.

The constipation section appears later under its own heading so that if a modification of the bowel regiment 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 that day by the team it is almost always good practice to check for impaction.

# Bisacodyl

Dosage	Complex	Route	Schedule (Day-Of-Week)	PRN
5MG		ORAL	BID	
5MG	0.0226	ORAL	QD	
10MG	0.0452		AC	
15MG	0.0679		AC/HS	
20MG	0.0904		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	
			NOV	
			ON CALL	
			ON CALL-OR	
			ONCE	
			ONE TIME	

Comments:

Give additional dose now

Admin Time: 0900-2100

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

BISACODYL TAB.EC  
5MG PO BID

Priority: ROUTINE

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 not 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	0.0120	ORAL	BID PRN
8.6MG	0.0064	ORAL	BID
17.2MG	0.0120	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
			NOV
			ON CALL
			ON CALL-OR

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

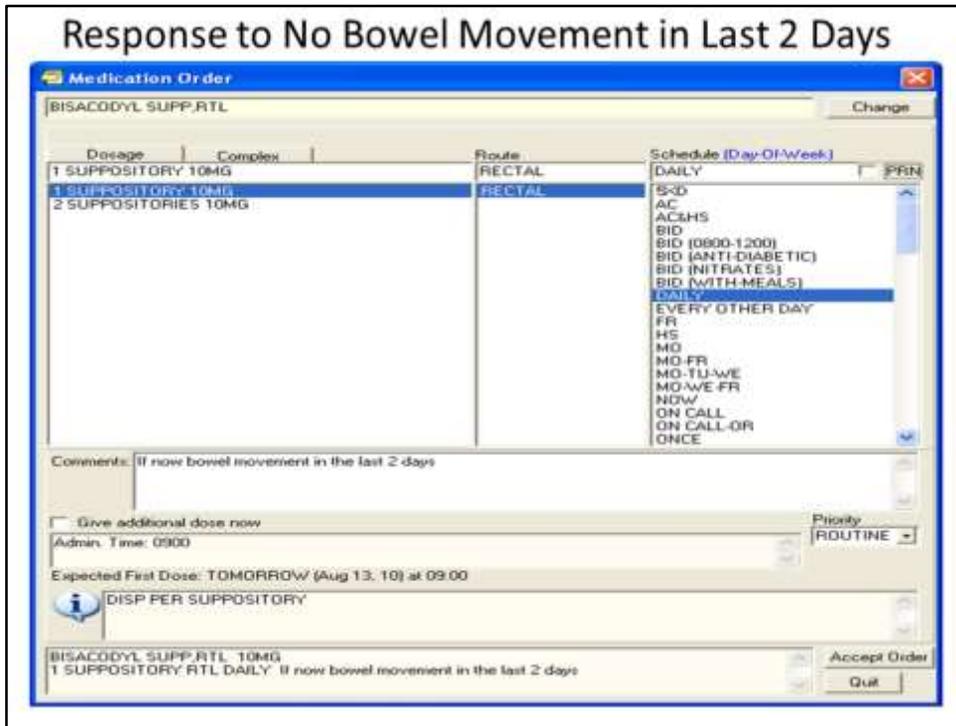
Senna is an effective laxative for constipation and may be the preference of the patient or clinician. The default dose is 2 tablets BID since this comparable to the bisacodyl dose in the previous slide.

# Docusate: A Stool Softener



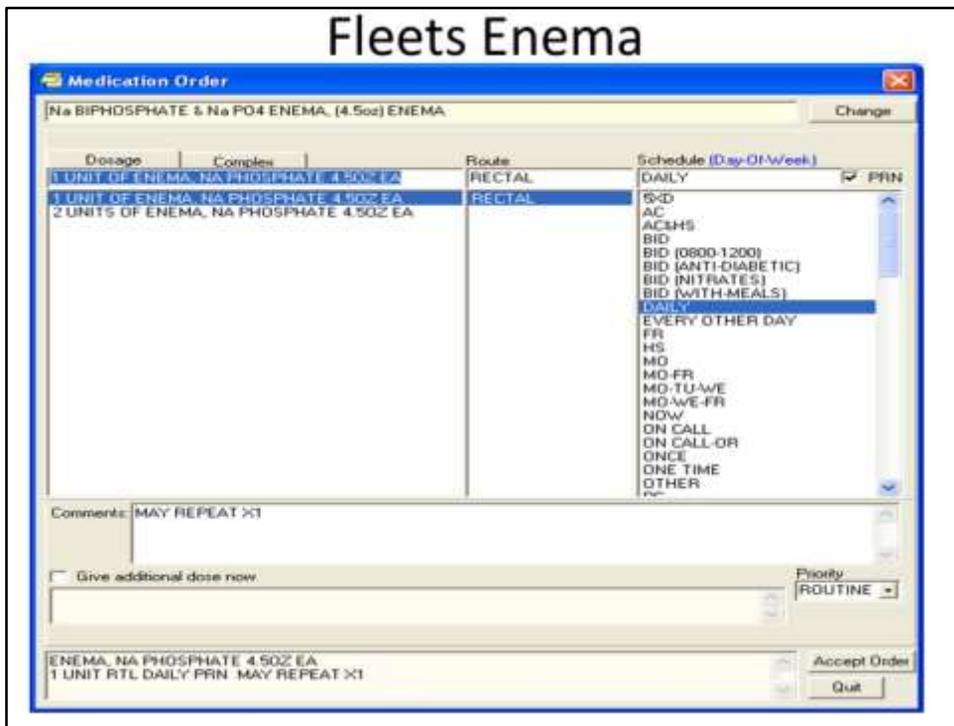
## Docusate

This is a stool softener and not a laxative. It is commonly given with a senna or bisacodyl to aid with elimination. Docusate only is not adequate for opioid constipation prophylaxis. Unfortunately many providers seem to think this is a laxative and do not understand that it



### Bisacodyl Suppository

In patient 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

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

Other treatments for constipation are available:

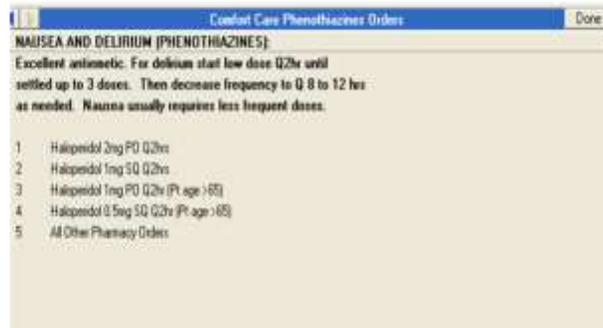
The hospice and palliative care team may need to recommend the addition of other medications for constipation. The relative merit of including them on a CCOS is to weigh the need for simplicity and present what would normally be the first line management that you would think appropriate for most patients and guide clinicians.

1) Polyethylene Glycol (Miralax) is an effective laxative and may be a good adjuvant as part of 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 on opioid 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 as opposed to 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, can be given both PO/IV/SQ so can always be administered and if not adequately effective the palliative care team can adjust after 12-24 hours.

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. This medications have similar modes of action as prochlorperazine (Compazine) or metoclopramide. Therefore haloperidol is helpful for two common symptoms.

## Nausea and Delirium (Phenothiazines)

### Comfort Care Phenothiazines Orders

#### 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. Nausea usually requires less frequent doses.

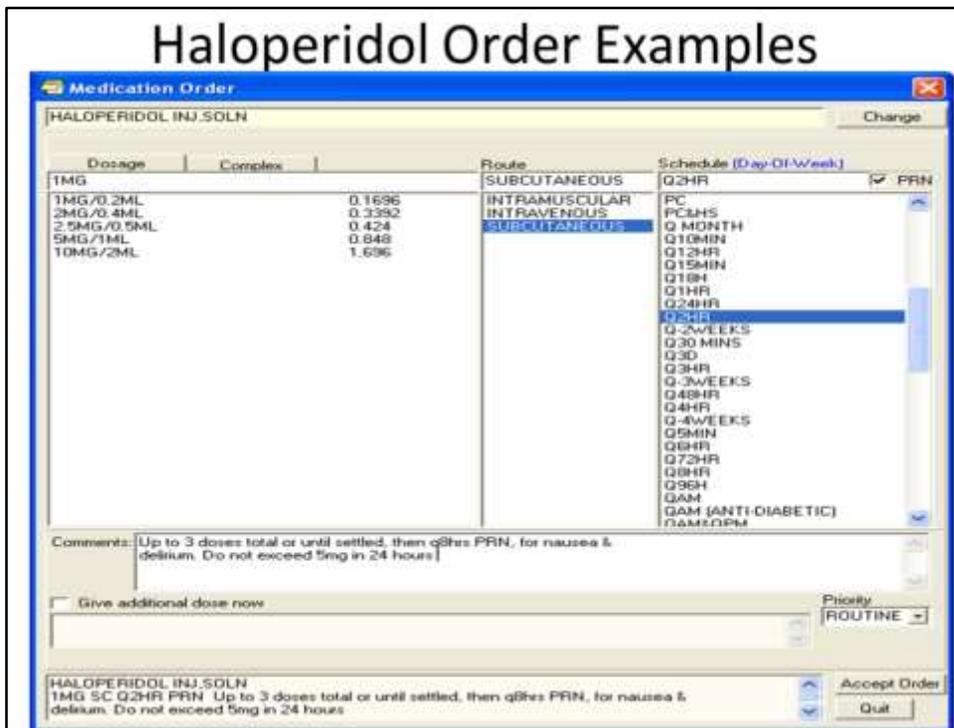
- 1 Haloperidol 2mg PO Q2hrs
- 2 Haloperidol 1mg SQ Q2hrs
- 3 Haloperidol 1mg PO Q2hr (Pt age >65)
- 4 Haloperidol 0.5mg SQ Q2hr (Pt age >65)
- 5 All Other Pharmacy Orders

### 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 dose SQ is half the oral dose since it is more potent in this form. It is advised that an order be placed so that if problematic symptoms do arise that staff can respond quickly.

The observation of 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 that taking an oral medication when nauseous or when vomiting is difficult.

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



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

Please 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 and the q 2 hours 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 a 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, recommendation from the hospice and palliative care team for treatment plan modifications will be needed.

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	Route	Schedule (Day/Of/Week)	PRN
2MG		ORAL	Q2HR	<input checked="" type="checkbox"/>
0.5MG	0.023	ORAL	PC	
1MG	0.0817	NG TUBE	PC4HS	
3MG	0.153	G TUBE	Q MONTH	
4MG	0.102	J TUBE	Q10MIN	
5MG	0.0992	PEG TUBE	Q12HR	
10MG	0.1984		Q15MIN	
			Q18H	
			Q1HR	
			Q24HR	
			Q30H	
			D-3WEEKS	
			Q30 MINS	
			Q3D	
			Q3HR	
			Q-3WEEKS	
			Q48HR	
			Q4HR	
			Q-4WEEKS	
			Q5MIN	
			Q6HR	
			Q72HR	
			Q8HR	
			Q9H	
			QAM	
			QAM (ANTI-DIABETIC)	
			QAM5QPM	
			QHS	
			QHS PRN	

Comments: Up to 3 doses total or until settled, then q4hrs 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 q4hrs PRN, for nausea & delirium. Do not exceed 6 mg in 24 hours

Accept Order  
Quit

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

# Haloperidol Order Examples

Dosage	Complex	Route	Schedule (Day/Of/Week)
1MG		ORAL	Q2HR <input checked="" type="checkbox"/> PRN
0.5MG	0.023	ORAL	PCMS
1MG	0.051	NG TUBE	Q MONTH
2MG	0.102	Q TUBE	Q10MIN
4MG	0.0992	J TUBE	Q12HR
5MG		PEG TUBE	Q15MIN
10MG	0.1994		Q18H
			Q1HR
			Q24HR
			ORAL
			Q-2WEEKS
			Q30 MINS
			Q3D
			Q3HR
			Q-3WEEKS
			Q48HR
			Q4HR
			Q-4WEEKS
			Q5MIN
			Q6HR
			Q72HR
			Q8HR
			Q9H
			QAM
			QAM (ANTI-DIABETIC)
			QAM&QPM
			QHS

Comments: Up to 3 doses total or until settled, then q2hrs 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 q2hrs PRN, for nausea & delirium. Do not exceed 5 mg in 24 hours

Accept Order  
Quit

Example 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 have low body weight.

All of 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

The screenshot shows a medical software interface with a blue header bar containing the text "Critical Care Medication Orders" and "LUPRO". Below the header, the text "NAUSEA AND DELIRIUM (PHENOTHIAZINES):" is displayed, followed by the instruction: "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. Na". A "View" button is visible on the right side of this section.

A "Medication Order" window is open, displaying a list of medication options. The list includes:

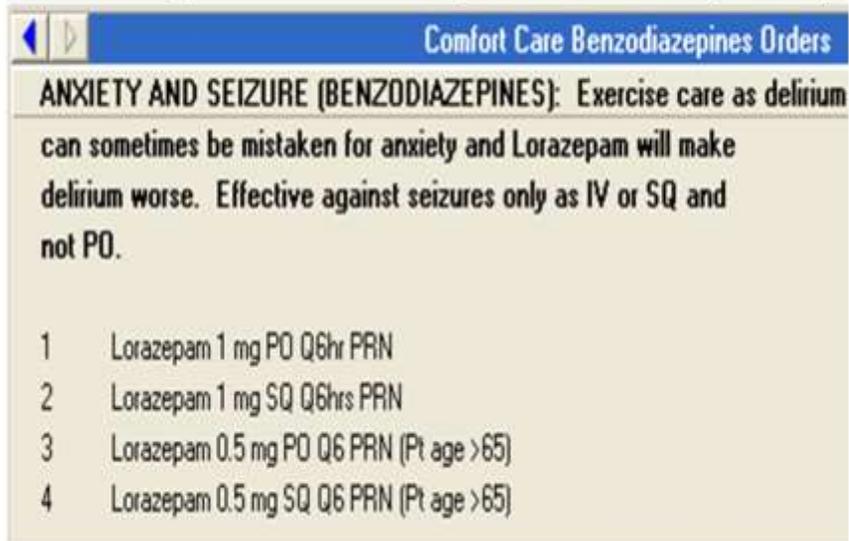
- 1 Haloperidol
- 2 Haloperidol
- 3 Haloperidol
- 4 Haloperidol
- 5 All Other Ph

The medication order window shows a list of items with their respective codes and descriptions:

- (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 >
- 0.9% SODIUM CHLORIDE <SODIUM CHLORIDE 0.9% INJ >

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

## Anxiety and Seizure(Benzodiazepines)



The screenshot shows a medical order form with a blue header bar containing the text "Comfort Care Benzodiazepines Orders". Below the header, the text reads: "ANXIETY AND SEIZURE (BENZODIAZEPINES): Exercise care as delirium can sometimes be mistaken for anxiety and Lorazepam will make delirium worse. Effective against seizures only as IV or SQ and not PO." Below this text is a list of four order options:

- 1 Lorazepam 1 mg PO Q6hr PRN
- 2 Lorazepam 1 mg SQ Q6hrs PRN
- 3 Lorazepam 0.5 mg PO Q6 PRN (Pt age >65)
- 4 Lorazepam 0.5 mg SQ Q6 PRN (Pt age >65)

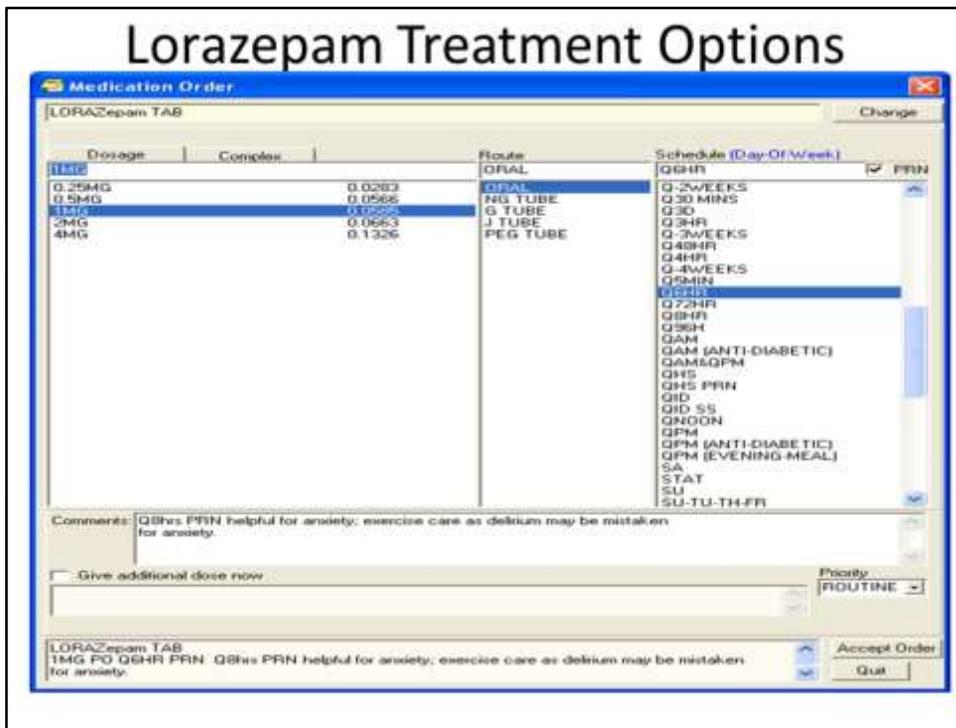
### Anxiety and Seizures

Anxiety and Seizures are distressing symptoms that can occur to patients at the end-of-life. Using the Portmanteau medication guideline, lorazepam is a good choice for a benzodiazepine since it can be given both PO/IV/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 related 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 not PO. Patients with history of seizures or who have 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 parental routes and dose adjustment for older patients.



Lorazepam for anxiety and seizures

Lorazepam 1mg PO q 6HR PRN

Please 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 always a warning to nursing staff to consider delirium as cause of anxiety and agitation and consider if treatment for delirium may be indicated first.

There are orders for both oral and parental forms of the lorazepam. Please remember that only parental forms should be used to treat seizures.

# Lorazepam Treatment Options

**Medication Order**  
LORAZEPAM INJ

Dosage / Rate	Complex	Route	Schedule (Day-Of-Week)	PRN
0.5MG/0.25ML	0.128	SUBCUTANEOUS	Q6HR	<input checked="" type="checkbox"/>
1MG/0.5ML	0.256	IV PUSH	Q-2WEEKS	<input type="checkbox"/>
2MG/1ML	0.512	INTRAMUSCULAR	Q30 MINS	<input type="checkbox"/>
3MG/1.5ML	0.768	INTRAVENOUS	Q3HR	<input type="checkbox"/>
4MG/2ML	1.024	NASAL	Q-3WEEKS	<input type="checkbox"/>
6MG/3ML	1.536	SUBCUTANEOUS	Q48HR	<input type="checkbox"/>
			Q4HR	<input type="checkbox"/>
			Q-4WEEKS	<input type="checkbox"/>
			Q7MIN	<input type="checkbox"/>
			Q6HR	<input type="checkbox"/>
			Q72HR	<input type="checkbox"/>
			Q8HR	<input type="checkbox"/>
			Q96H	<input type="checkbox"/>
			QAM	<input type="checkbox"/>
			QAM (ANTI-DIABETIC)	<input type="checkbox"/>
			QAM&QPM	<input type="checkbox"/>
			QHS	<input type="checkbox"/>
			QHS PRN	<input type="checkbox"/>
			QID	<input type="checkbox"/>
			QID SS	<input type="checkbox"/>

Comments: Q6hrs 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 Q6hrs PRN helpful for anxiety; exercise care as delirium may be mistaken

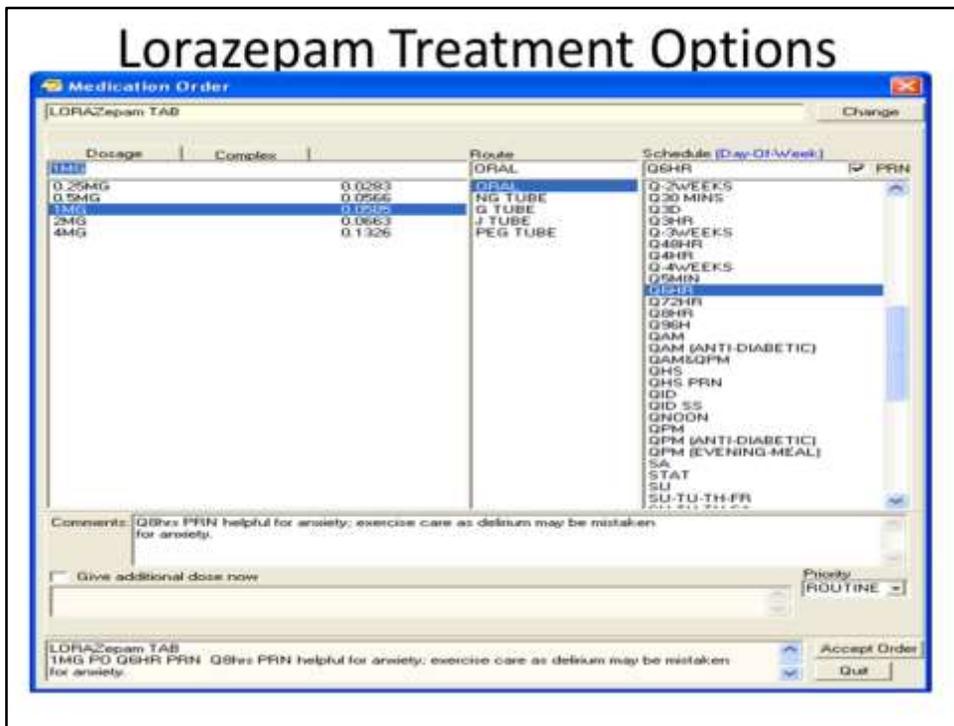
Accept Order  
Quit

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 always a warning to nursing staff to consider delirium as cause of anxiety and agitation and consider if treatment delirium may be indicated first.

There are both orders for oral and parental forms of the lorazepam. Please remember that only parental forms should be used to treat seizures.



Lorazepam 0.5MG PO q 6HR PRN

Example 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 have low body weight.

All of 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	Route	Schedule [Day-Of/Week]
0.1MG/0.25ML		SUBCUTANEOUS	Q6HR <input checked="" type="checkbox"/> PRN
0.5MG/0.25ML	0.128	IV PUSH	Q-2WEEKS
1MG/0.5ML	0.256	INTRAMUSCULAR	Q30 MINS
2MG/1ML	0.512	INTRAVENOUS	Q3D
3MG/1.5ML	0.768	NASAL	Q3HR
4MG/2ML	1.024	SUBCUTANEOUS	Q-3WEEKS
6MG/3ML	1.536		Q48HR
			Q4HR
			Q-4WEEKS
			Q5MIN
			Q6HR
			Q72HR
			Q84HR
			Q96H
			QAM
			QAM (ANTI-DIABETIC)
			QAM&QPM
			Q12

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

Give additional dose now Priority ROUTINE

**i** 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 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 have low body weight.

All of 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 preferred due to insomnia.

Dexamethasone 1mg is equivalent to Prednisone 6mg.

10 Dexamethasone 4 to 8 mg PO BID with meals

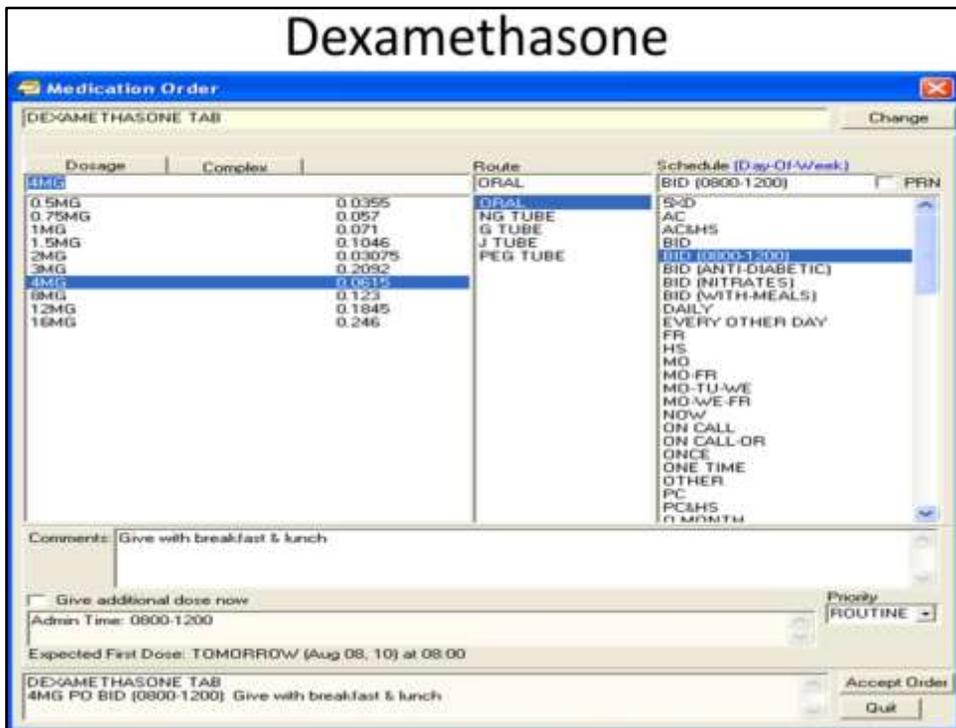
11 Dexamethasone 4 to 8 mg SQ BID (subq not compatible with hydromorphone)

## 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 may see an improvement in appetite and energy level although the effects are usually short lived lasting for 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 a corticosteroid of choice in this setting. Dexamethasone has flexibility in that it can be given PO/IV/SQ and is of equivalent strength in oral and parental forms. No other commonly used corticosteroid has this flexibility. Since 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 in clinical practice has not seemed to be a common issue.



## Dexamethasone

Please note the following features of this order

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

Dexamethasone 4mg is approximately equivalent to prednisone 15mg. Therefore dexamethasone 16mg a 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 dexamethasone 40-100mg/day, the benefit of these strategies is not clearly demonstrated.

This order plan of dosing 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** Change

[DEXAMETHASONE INJ SOLN] Change

Dosage	Complex	Route	Schedule (Day-Of-Week)
4MG/1ML		SUBCUTANEOUS	BID (0800-1200) PRN
4MG/1ML	0.578	INTRAMUSCULAR/IA	5-D
6MG/1.5ML	0.807	INTRAMUSCULAR	AC
6MG/2ML	1.076	INTRAVENOUS	AC&HS
10MG/2.5ML	1.345	SUBCUTANEOUS	BID
12MG/3ML	1.614		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
			ONCE TIME

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

Give additional dose now Priority

Admin Time: 0800-1200 ROUTINE

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 parental version of the oral 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 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 can escalate the dose and if still not effective then discontinue.

This medication is particularly helpful if the patient has been on corticosteroids and 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

The screenshot shows a medical order entry window titled "Constipation". The window has a blue header bar with the text "Comfort Care Constip.". Below the header, there is a yellow bar with the text "CONSTIPATION: Initiate if on opioids or no BM x 2 days.". The main content area is a list of eight items, each with a number and a description:

- 1 Please check for impaction
- 2 Bisacodyl 5mg PO BID
- 3 Sennosides 17.2mg PO DAILY (may crush)
- 4 Docusate 250mg PO BID
- 5 MDM 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 regiment 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 branch point.

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

# Management of Secretions

The image shows a screenshot of a medical order set titled "Comfort Care Death Rattle Order". The main instruction is "DEATH RATTLE: Keep back of throat dry by turning head to side." Below this, it says "Stop IVF or tube feeding." There is a numbered list of six items:

- 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.

## 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, the loud noises are distressing to families concerned that their loved one is suffering.

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

The following menu offers a number of options for management of secretions. The relative superiority of one approach to another has not been determined. However, all of the medications work by drying the mouth and throat. These medications do 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)	PRN
1 PATCH 0.33MG/24HRS	NF	TOPICAL TOPICAL MISCELLAN	Q72HR Q30 MINS Q30 Q3HR Q3WEEKS Q48HR Q4HR Q4WEEKS Q5MIN Q6HR <b>Q72HR</b> Q8HR Q96H QAM QAM (ANTI-DIABETIC) QAMBQPM 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	<input type="checkbox"/>

Comments: Place behind ear.

Give additional dose now  
 Admin Time: 0900  
 Expected First Dose: TOMORROW (Aug 08, 10) at 09:00

Priority: **ROUTINE**

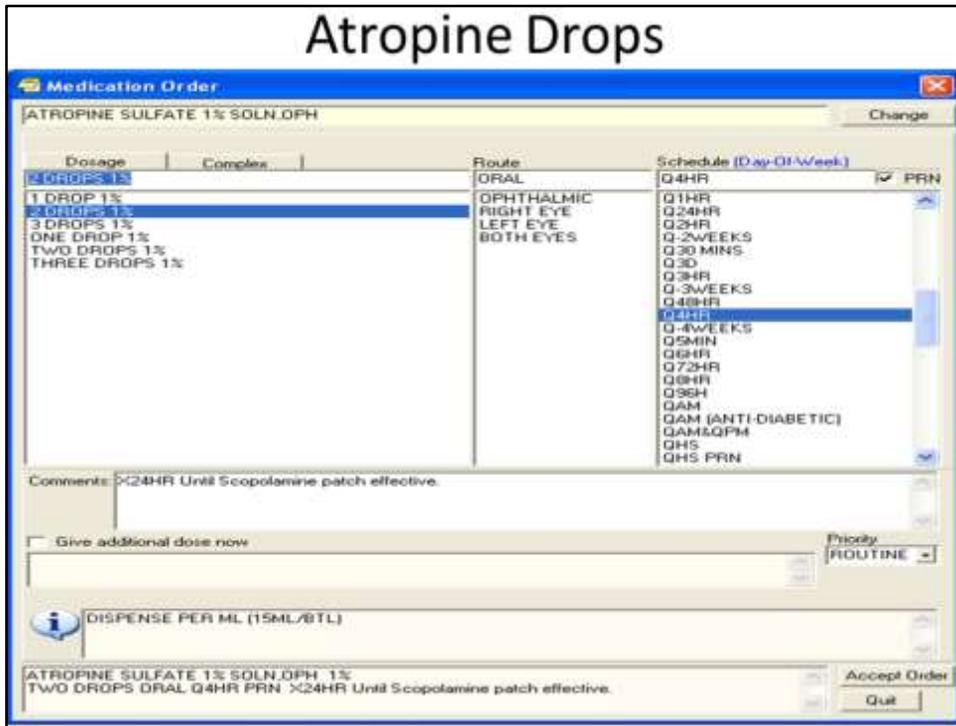
SCOPOLAMINE TRANSDERMAL PATCH  
 1 PATCH TOP Q72HR Place behind ear. Accept Order

## Scopolamine Patches

This medication has often been used in the home hospice setting. One advantage is that the patch can be placed and for most patients will not need to be replaced 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 and if there is a need to discontinue the medication the scopolamine may linger in the subcutaneous depot.

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.

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

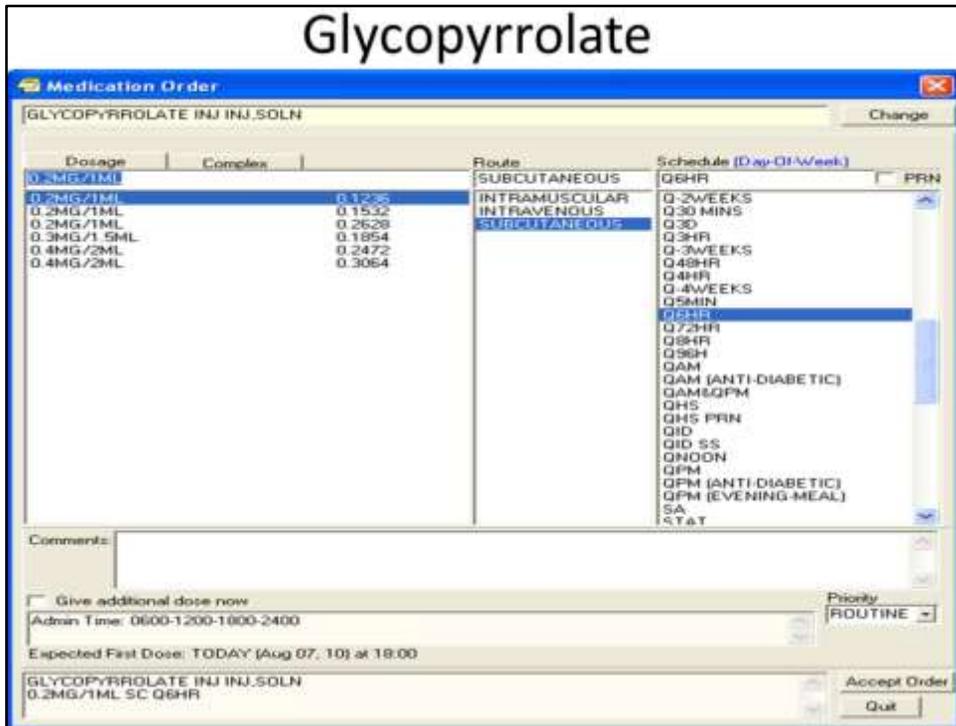


## Atropine Eye Drops

Atropine is well known to dry oral secretions. This treatment plan has also been used in the home hospice setting and is convenient since it can be given orally.

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

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



## Glycopyrrolate

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

For patients with very difficult to control secretions an increase in frequency to q 4 and/or the dose may be considered.

# Mouth Care

**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

Patient at the end-of-life often need and benefit from mouth care. All patients who receive medications 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 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 use to clean and moisten the mouth. Patients often may benefit from this more often than the order of Q 4hours. Therefore the order suggests that if family would like to participate in care, that mouth care is something that they can be instructed in.

# 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% oph sol 2 gtt each eye q6hr  
5 Lacri Lube oph oint thin ribbon of Lacri Lube both eyes 6qhr

**Sore mouth:**  
6 Mylanta benedyl 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

**Diarhea:**  
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 and the BEACON project was first developed this was not an option that was in use. However, it became clear that many of the orders of the CCOS were good options for both patients who were actively dying as well as patients earlier in their hospital or CLC course. Therefore this menu option was created to remind providers of other medications that might be helpful and save time of having to enter the orders through the pharmacy menu.

# Demonstration of Menu

The screenshot shows a medical software interface with a list of symptoms on the left and a 'Medications Order' dialog box in the center. The dialog box contains a table with columns for Dosage, Complex, Route, and Schedule. A dropdown menu is open under the 'Route' column, showing options like ORAL, NG TUBE, G TUBE, J TUBE, PEG TUBE, QHS, QAM, QAM (ANTI-DIABETIC), QAM/QPM, QHS, QID, and qn. cc. The 'QHS PRN' option is selected.

Dosage	Complex	Route	Schedule (Day/Of/Week)
25MG	0.02965	ORAL	QHS PRN
50MG	0.0593	ORAL	Q5MIN
75MG	0.08895	NG TUBE	Q6HR
100MG	0.0863	G TUBE	Q72HR
150MG	0.12915	J TUBE	Q8HR
200MG	0.1722	PEG TUBE	Q9HR
			QAM
			QAM (ANTI-DIABETIC)
			QAM/QPM
			QHS
			QID
			qn. cc

Comments: PRN INSOMNIA, MAY REPEAT IN 1HR

Give additional dose now  Priority: ROUTINE

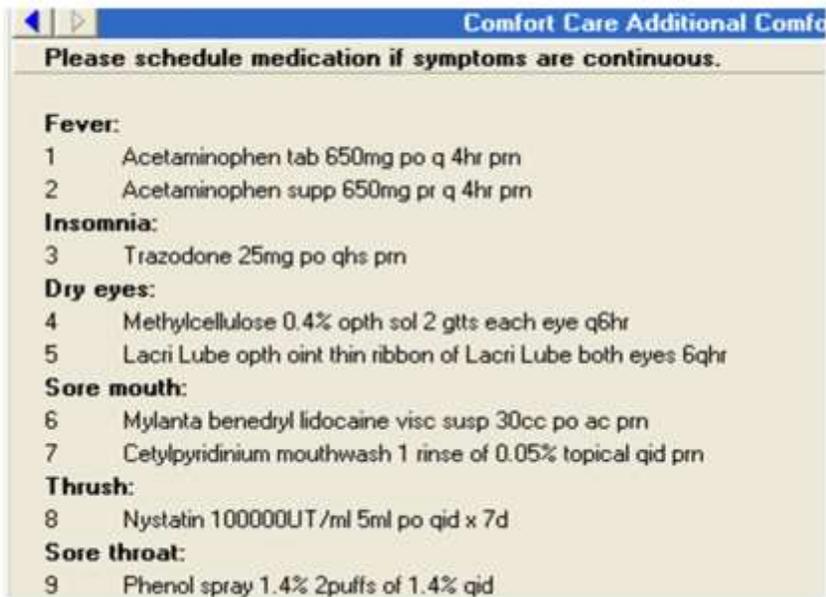
Enter exact dose/freq; no range orders permitted

Accept Order | Quit

Menu option demonstrated

All of these options open to a default of the lower dose and most common route and frequency. This 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% oph sol 2 gtt: each eye q6hr
- 5 Lacri Lube oph 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 1000000UT/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

The screenshot shows a window titled "Consider Consults" with a blue header bar containing navigation arrows and the word "Comfort". Below the header is a list titled "Consults to Consider:" with 11 numbered items. Item 6, "Mental Health", is highlighted in blue. The other items are: 1 Social Work Consult, 2 Chaplain Consult, 3 Palliative Care Consult, 4 Pharmacy, 5 Geriatric, 7 Physical Therapy, 8 Occupational Therapy, 9 Speech Consult, 10 Wound Care/Skin Risk Mgmt. Consult, and 11 All Other Consults.

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

### Consider Consults

Hospice and Palliative Care patients are best served in an interdisciplinary team approach. Frequently there are multiple needs so that it is prudent to consult one or more supporting services.

One of the consult options is Palliative Care. Since any clinician may encounter patients at end-of-life they will want to consider the orders in the CCOS. On some occasions these providers could 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  
 Patient will be seen as an:  
 Inpatient  Outpatient  
 Place of Consultation: BEDSIDE

Provisional Diagnosis:

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 with the additional information that that service may need in order to respond appropriately.

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

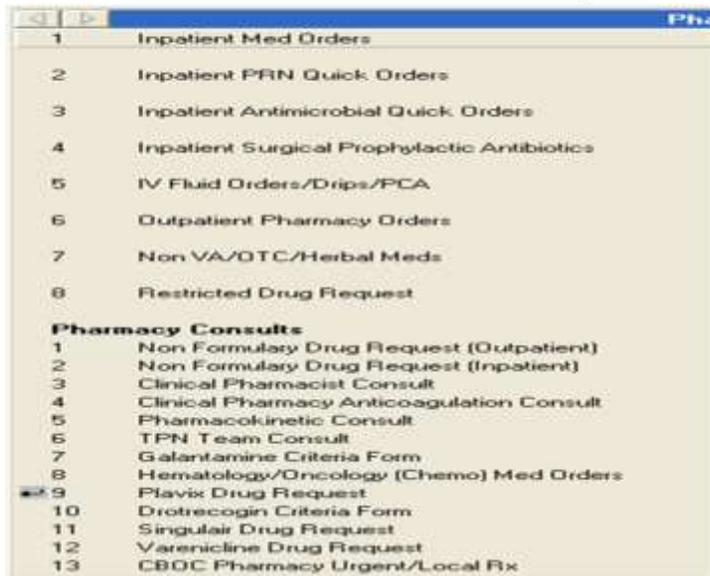
# Laboratory

The screenshot shows a 'Lab Menu' window with a blue header. Below the header, there is a section titled 'ATTENTION' with a warning: 'ICUs and ER use WARD COLLECT as the COLLECT!'. The menu lists 13 items, with item 4, 'Lab Microbiology Quick Order', highlighted. Below the list, there is a section titled 'Please order BK Look Back Labs below ONLY' with items 9 and 10.

*****ATTENTION***** ICUs and ER use WARD COLLECT as the COLLECT!	
1	Lab Panel/Profile Quick Order
2	Chem/Heme Quick Order
3	Lab Drug Level/Toxin Quick Order
4	Lab Microbiology Quick Order
5	Lab Urine Quick Order
6	Lab Body Fluid Quick Order
7	HIV ANTIBODY TEST
8	Employee Health Pre Appointment Profile
*****	
Please order BK Look Back Labs below ONLY	
*****	
9	BK Look Back Labs
10	Other Lab Tests

In some Palliative Care patients some laboratory studies may be helpful and still can order and use CCOS.

# Other Pharmacy



1	Inpatient Med Orders
2	Inpatient PRN Quick Orders
3	Inpatient Antimicrobial Quick Orders
4	Inpatient Surgical Prophylactic Antibiotics
5	IV Fluid Orders/Drips/PKA
6	Outpatient Pharmacy Orders
7	Non VA/OTC/Herbal Meds
8	Restricted Drug Request
<b>Pharmacy Consults</b>	
1	Non Formulary Drug Request (Outpatient)
2	Non Formulary Drug Request (Inpatient)
3	Clinical Pharmacist Consult
4	Clinical Pharmacy Anticoagulation Consult
5	Pharmacokinetic Consult
6	TPN Team Consult
7	Galantamine Criteria Form
8	Hematology/Oncology (Chemo) Med Orders
9	Plavix Drug Request
10	Drotrecogin Criteria Form
11	Singular Drug Request
12	Varenicline Drug Request
13	CBOC Pharmacy Urgent/Local Rx

In some Palliative Care patients some other medications may be helpful and still can order and use CCOS.

# Radiology

A screenshot of a software interface for Radiology/Imaging Orders. The title bar is blue with the text "RADIOLOGY/IMAGING ORDERS" in white. Below the title bar, the main content area has a light beige background. It contains the following text:

**A DIAGNOSIS (or rule out diagnosis) is REQUIRED in the "History & Reason for Exam" field on ALL RADIOLOGY ORDERS.**

**The DESIRED DATE entry should be appropriate for patient indications and coordination of care and follow up**

Radiology/Imaging

Radiology Interventional

In some Palliative Care patients some radiology studies may be helpful and still can order and use CCOS.