MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

PRE-PRINTED ORDER RECORD

Allergies *(also specify reaction)*	☐ None known
Diagnosis	

Write firmly for legible copy

Comfort Care / End of Life

PLEASE NOTE: This routine order is **ONLY** to be used when patient is in the **last hours/days** of life.
Please see reverse for additional information regarding end of life symptom management.

1. Resuscitation Status ☑ DNR (document resuscitation status in chart)

2. Consultation ☐ Palliative Medicine ☐ Chaplain ☐ Social Work ☐ Pharmacy ☐ Comfort Tray for Family ☐ Other: _____

3. Pain

A. If patient currently on opioid:

i) Discontinue ALL previous PO opioids.

ii) Convert current regimen to IV or SC (see reverse for details). Parenteral dose should be one-half (1/2) of oral dose. Some patients may require less opioid at end of life. Consider a small decrease in dose or hold opioids for a time if signs of opioid toxicity such as myoclonus (twitching), sedation and confusion.

iii) New opioid regimen:

☐ Morphine _____ mg IV/SC q4h

OR

☐ HYDROmorphone _____ mg IV/SC q4h

iv) New breakthrough opioid regimen (breakthrough dose is usually 1/2 of the q4h dose).

☐ Morphine _____ mg IV/SC q30min PRN for pain

OR

☐ HYDROmorphone _____ mg IV/SC q30min PRN for pain

B. If patient is opioid naïve consider starting:

Choose one:

☐ Morphine _____ mg IV/SC q30min PRN for pain
(usual range 1-4 mg)

OR

☐ HYDROmorphone _____ mg IV/SC q30min PRN for pain
(usual range 0.2-0.6 mg)

4. Delirium (Agitation/Confusion)

☐ Haloperidol 0.5-1 mg PO/SC q8h PRN for agitation hallucinations or delirium

☐ Methotrimeprazine (Nozinan) 12.5 mg - 25 mg SC q8h PRN for severe agitation or distress, if haldoperidol not effective

5. Dyspnea

☐ Morphine _____ mg IV/SC q30min PRN for dyspnea or increase current opioids by 25% unless signs of toxicity
(usual range 1-4 mg)

☐ Lorazepam 1-2 mg IV/SC q2h PRN for dyspnea unrelieved by opioids

☐ Titrate supplemental oxygen via NP to relieve dyspnea to a maximum of 6L/min.

☐ Educate family about observed respiratory changes at the end of life - see reverse for information

6. Antipyretic/Analgesia ☐ Acetaminophen 650 mg PO/PR q4h PRN pain or fever. (Max 4 g in 24 hr)

7. Respiratory Secretions

☐ Hyoscine hydrobromide (scopolamine) 0.4 mg SC q4h PRN for excess secretions

☑ No deep suctioning unless absolutely necessary

☑ Position patient in semi-prone position

8. Sedation (choose one)

☐ LORazepam (Ativan) 1-2 mg PO/SL q1h PRN for restlessness, anxiety, insomnia

☐ Midazolam (Versed) 5 mg SC q20min PRN for severe agitation or distress or acute bleeding

Other: _____

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Clearly imprint patient identification card

Comfort Care / End of Life

9. Parenteral fluids

Consider whether non-enteral hydration is necessary for patient comfort. In some cases, it is best to discontinue parenteral fluids and other cases it may be best to continue fluid at a lower rate. (See reverse for details). If fluids are given, assess frequently for CHF and peripheral edema.

☐ Saline Lock

☐ Discontinue intravenous fluids

☐ Normal Saline IV _____ mL/hr

☐ SC hydration (Hypodermoclysis): Normal Saline SC _____ mL/hr

Other: _____

10. Elimination

Assess for urinary retention

☐ Insert urinary catheter PRN

☑ Moisturizing Cleanser for peri care PRN

11. Mouth and Eye Care

☐ Baking soda saline mouthwash apply topically q1h PRN. Mix 1/2 tsp sodium bicarb with 1/2 tsp salt in 500 mL water. Solution should be discarded after 24 hours and a new solution prepared daily.

☐ Oral base gel (Vaseline) topically to lips q2h PRN

☐ Natural tears 1-2 drops to both eyes q2h PRN

12. Oral Intake

☐ Diet as tolerated ☐ May take medications with sips of water ☐ Dysphasia diet ☐ NPO

☐ Parenteral feeds: _____

☐ Soft foods prn for comfort (families may accept risk of aspiration): _____

13. ☐ Insert an SC butterfly for the administration of SC medications. Each SC medication requires a seperate SC butterfly.

14. Discontinue Orders

Review current medications. Discontinue those that are burdensome to the patient and non-essential medications. Many patients at the very end of life do not require standing medications e.g. for diabetes, etc. Discuss this with patient and family. **Continue** medications that add to patient comfort (e.g. furosemide).

☑ Discontinue all medications ***except:***

DRUG	DOSE	ROUTE	FREQUENCY	INDICATION

☐ Discontinue routine vitals and oxygen saturation measurement

☐ Discontinue routine blood work, diagnostic procedures, and interventions

☐ Discontinue parenteral feeding or g-tube feeding if patient and family consent

☐ Patient has Internal Cardiac Defibrillator (ICD device) - contact Electrophysiology service to disable

If symptoms not well-controlled, patient may need sedation at the end-of-life. Please consult palliative care service if end of life symptoms not well-controlled.

15. Care After Death

☑ Notify Palliative Care Medicine consult team (if involved in care) during regular working hours

The care and treatment changes reflected in this orderset have been discussed with:

☐ Patient _____

☐ Family member (specify relationship and name) _____

☐ Other (specify) _____

Date	Time	Print Name	Signatures
(YYYY MM DD)	(HH:MM)		, M.D.
(YYYY MM DD)	(HH:MM)		Reviewed by , R.N.

Copy Distribution: White Original ➜ Patient Chart Yellow Copy ➜ Pharmacy

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Educating Families regarding Changes in Breathing Patterns:

Changes in breathing are common at the end of life and can be very distressing for family who fear that the patient may be suffocating. Educating families about these changes can be very helpful in alleviating concern.

Change in pattern: may be very regular, almost mechanical pattern as the automatic centre of the brain takes over control of breathing - breathing pattern may be of normal depth, shallow and/or more rapid.
Muscles used: accessory muscles are often used, which may make the shoulders lift up when patient is breathing in. If no other signs of distress, this is not a sign of dyspnea or struggling to breathe.
Pauses: Pauses in breathing (apnea) are common.
Cheyne-Stokes breathing pattern may occur: clusters of 5-10 rapid breaths that get deeper and deeper and then shallower and shallower. There may be apneic pauses as well.
Irregular breathing: In the final minutes or hours of life, there may be periods of very irregular breathing, with a few deep, irregular breaths.

Ongoing skin assessment and management of skin breakdown:
- Assess the need for a therapeutic surface.
- Ensure turning frequency is determined and outlined in patient's kardex.
- Documentation of assessments and interventions necessary.
- Completion and documentation of Braden Scale per unit policy is required.
- Consider involvement of skin and wound resource person.

Opioid conversion
1. Calculate current 24 hour dosage of opiate.
2. If dose was oral, convert to SC or IV by dividing oral dose in half (ie. parenteral opiate is twice as potent as oral) 24 hour SC or IV dose should be divided q4h to obtain a standing dose.
3. Provide a q30min PRN dose which is 50% of the q4h standing dose.
4. Preference is to choose SC dosing via an SC butterfly.
5. If the patient has been on a long acting opiate, the last oral dose will be in effect for 10-12 hours. Anticipate that parenteral demand may increase at that time.

DRUG	IV/SC	ORAL
Morphine	10 mg	20 mg
Codeine	100 mg	200 mg
HYDROmorphone	2 mg	4 mg
OxyCODONE	n/a	10 mg
FentaNYL	0.1 mg	n/a
Methodone	Call Palliative Care	

**Note: there are many variations of this chart. Conversion is subject to large inter-patient variability. It is recommended to be conservative when converting between opiates.
Patients may require more or less than predicted by these conversions.
Increase the frequency of monitoring for pain control and adverse effects after conversion.

Other palliative considerations:
- Arrange for a private room if possible
- Provide education to family about how to provide care (ie. administering eye drops, mouth care, monitoring for pain)
- Provide family "Last hours" information handout
- Request comfort tray and Palliative Volunteer Visit. Call Volunteer Services (Ext 8200) and ask for a palliative volunteer visit, which will include the provision of the comfort tray for family members. If there is not a palliative volunteer available, send your request for a comfort tray to Nutrition Services (Ext 5025) and send someone to pick it up.