Atlantic Health System

C-PCLC SYMPTOM ASSESSMENT & MANAGEMENT: IMPROVING QUALITY OF LIFE

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October 25, 2021

10 Common Chronic Conditions for Adults 65+

Quick Facts

80% have have at least 1 chronic condition

68% have 2 or more chronic conditions

Hypertension (High Blood Pressure) 58%

High Cholesterol 47%

Arthritis 31%

Ischemic Heart Disease (or Coronary Heart Disease) 29%

Diabetes 27%

SYMPTOM BURDEN OF CHRONIC ILLNESES

Chronic Kidney Disease 18%

Heart Failure 14%

Depression 14%

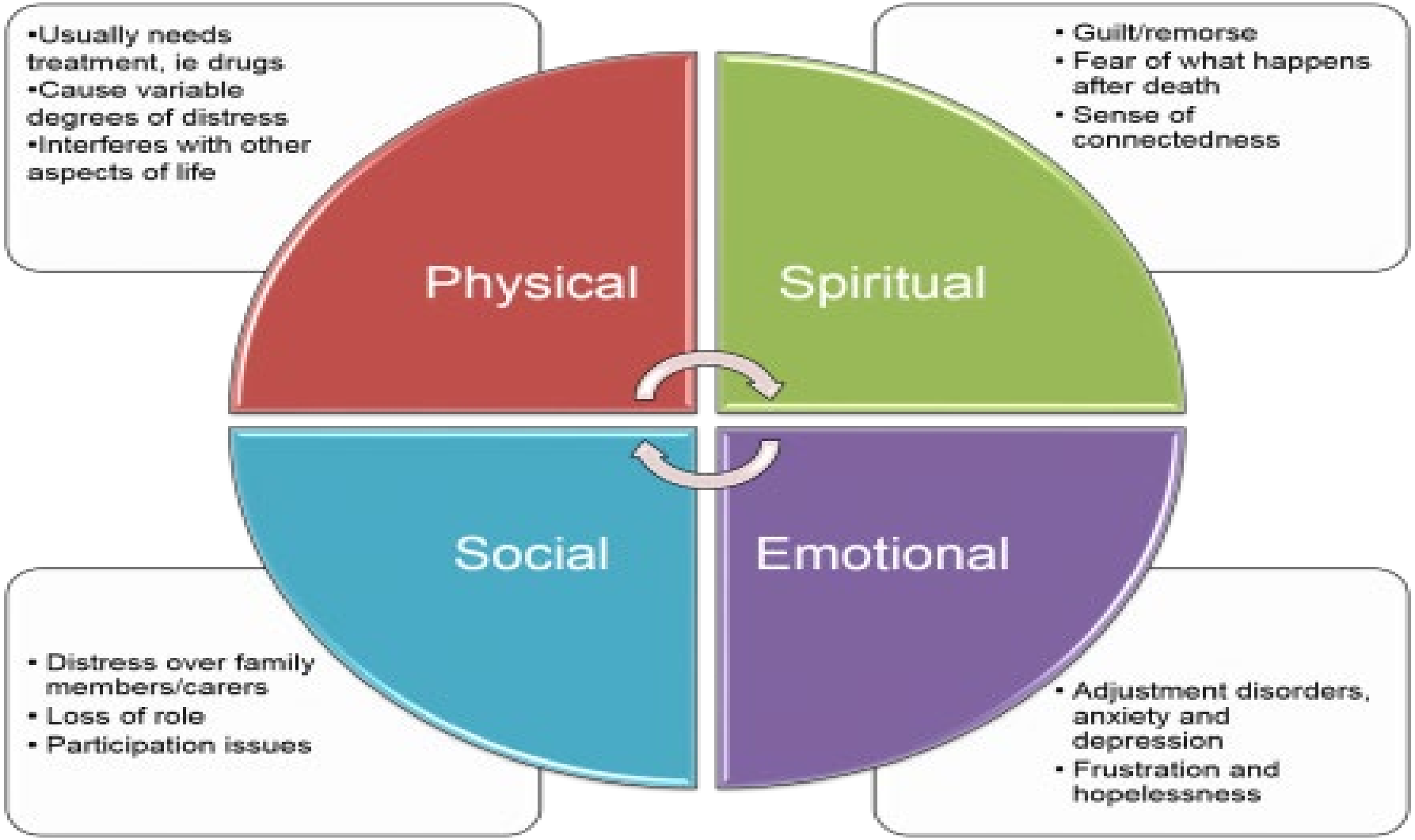
Alzheimer's Disease and Dementia 11%

Chronic Obstructive Pulmonary Disease 11%

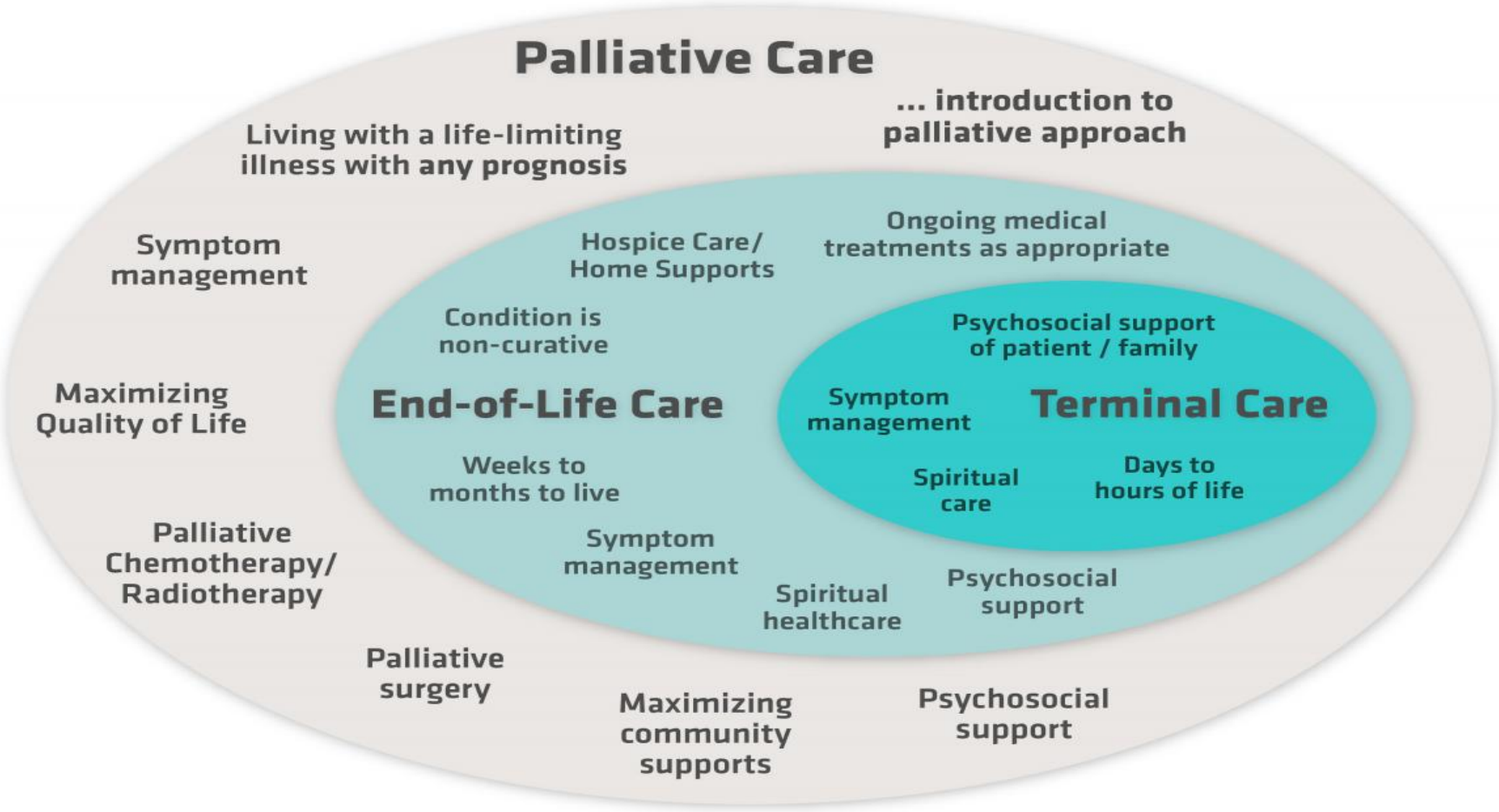
PALLIATIVE CARE: PRINCIPLES & PHILOSOPHY

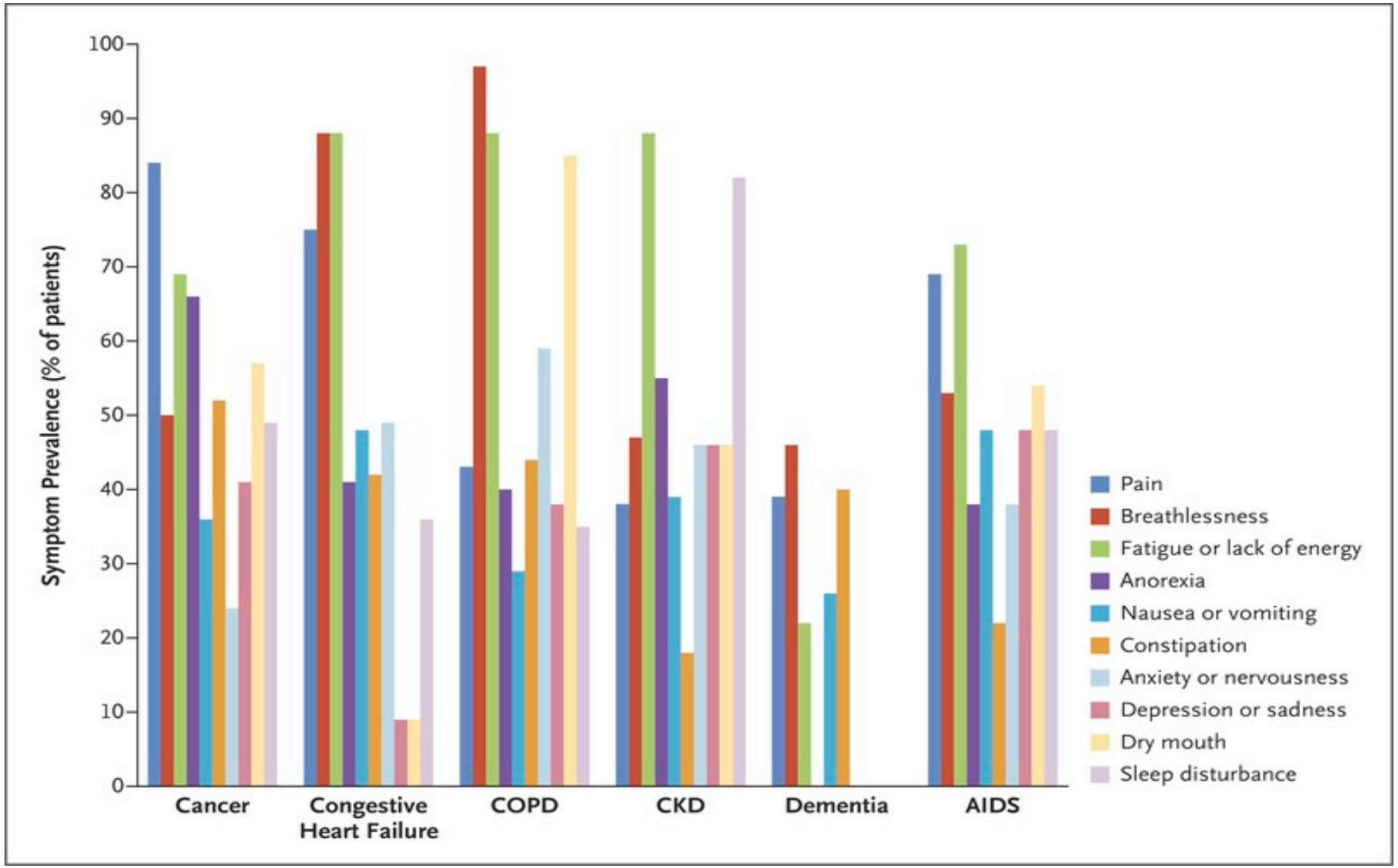
- Goals of palliative medicine
  - Prevent and relieve suffering
  - Promote physical and psychosocial health
  - Support for the best quality of life
- Whole-person care for the seriously ill
- A philosophy of care and an organized, structured system of care delivery
- Interdisciplinary team

CAPC 2019; WHO 2013

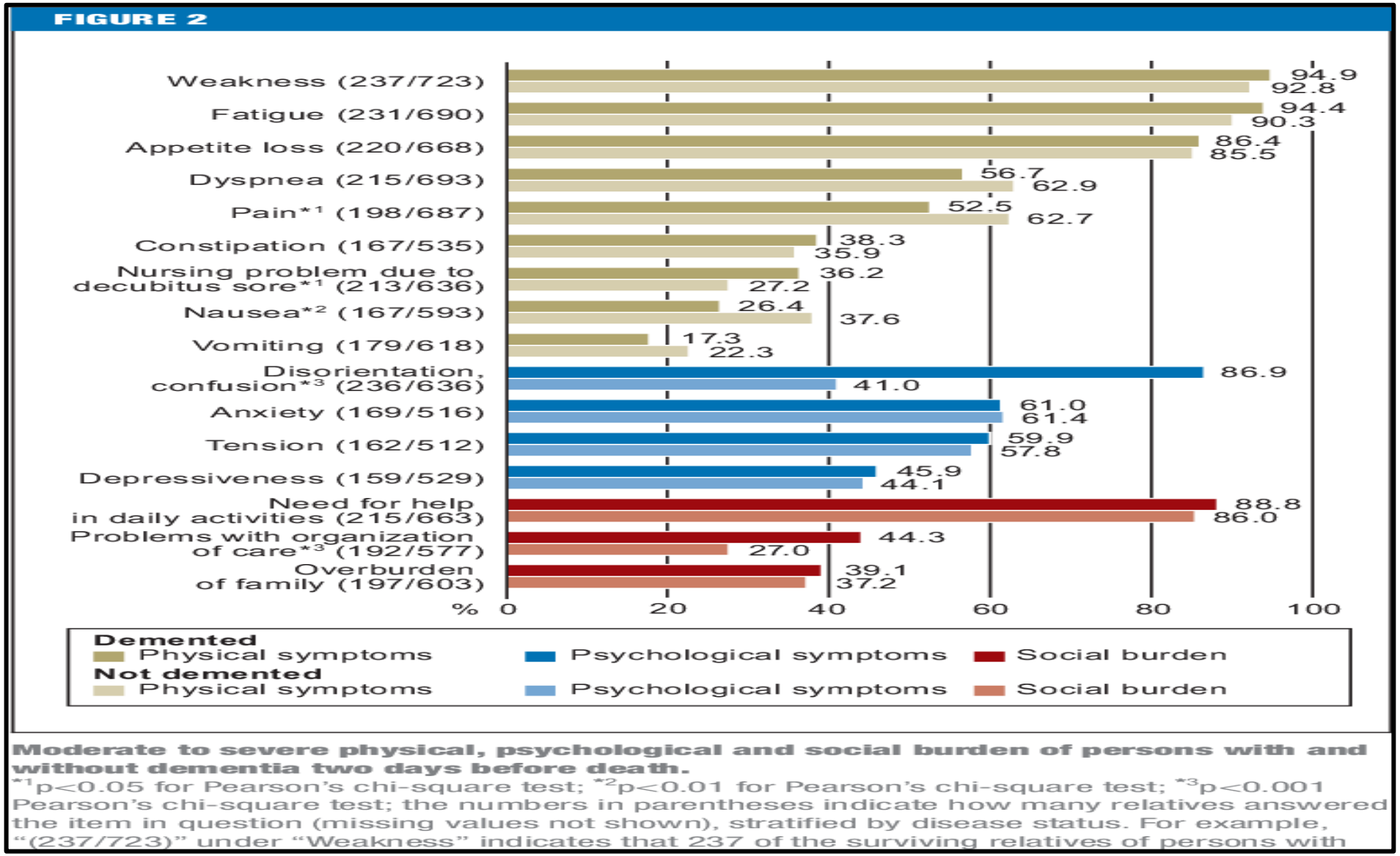


The phases and layers of care





N Engl J Med 2015; 373:747-755



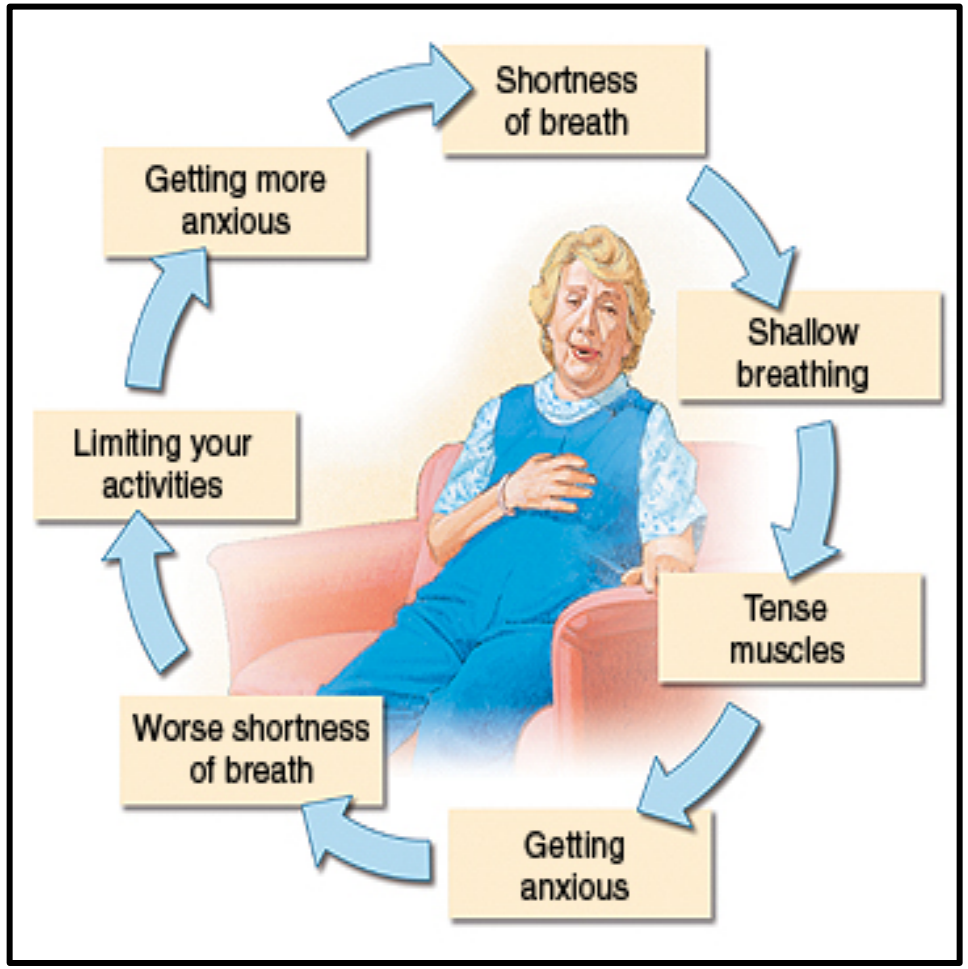
Moderate to severe physical, psychological and social burden of persons with and without dementia two days before death.

*1 $p<0.05$ for Pearson's chi-square test; *2 $p<0.01$ for Pearson's chi-square test; *3 $p<0.001$ Pearson's chi-square test; the numbers in parentheses indicate how many relatives answered the item in question (missing values not shown), stratified by disease status. For example, "(237/723)" under "Weakness" indicates that 237 of the surviving relatives of persons with

Dtsch Arztebl Int 2013; 110(12): 195-202. DOI: 10.3238/arztebl.2013.0195

DYSPNEA: ASSESSMENT & MANAGEMENT

DYSPNEA: MULTIDIMENSIONAL



Determine and assess cause/s of dyspnea

- Looking for reversible problems is always warranted
- ***Understanding where patients are at in the dying trajectory, and their identified goals of care, is essential to guide the extent of workup to discover reversible causes***

If the patient is clearly dying and the goals of care are comfort, then:

- pulse oximetry, arterial blood gases, EKG, or imaging are not indicated

Respiratory Distress Observation Scale (RDOS)

Purpose

This tool is to be used for assessing the intensity and distress of patients unable to report dyspnea during monitoring for Palliative Sedation Therapy[1,2,3].

Variable	0 Points	1 Point	2 Points	Sub-Total
Heart rate per min (beats / min = bpm)	less than 90 bpm	90 – 109 bpm	greater than or equal to 110 bpm	
Respiratory rate per minute (auscultated) (breaths / min)	less than 19 breaths	19 – 30 breaths	greater than 30 breaths	
Restlessness: non-purposeful movements	No	Yes - Occasional, slight movements	Yes - Frequent movements	
Paradoxical breathing pattern: abdomen moves in on inspiration	No		Yes	
Accessory muscle use: rise in clavicle during inspiration	No	Yes - Slight rise	Yes - Pronounced rise	
Grunting at end-expiration: guttural sounds	No		Yes	
Nasal flaring: involuntary movement of nares	No		Yes	
Look of fear: ☐ Eyes wide open ☐ Facial muscles tense ☐ Brow furrowed ☐ Mouth open ☐ Teeth together	No		Yes	
			Total	

Instructions for Use

- Count respiratory and heart rates for one full minute;
- Grunting may be audible with or without auscultation;
- An RDOS score of less than 3 indicates respiratory comfort[2];
- An RDOS score greater than or equal to 3 signifies respiratory distress and need for palliation[2,3];
- Higher RDOS scores signify a worsening condition[2,3].

References:

1. Campbell, M. L. (2008b). Psychometric testing of a respiratory distress observation scale. J Palliative Care Medicine, 11(1), 48.
2. Campbell, ML and Templin TN. (2015). Intensity cut-points for the Respiratory Distress Observation Scale. Palliat Med. 29(5): 436–442
3. Zhang et al. (2019). Validity, Reliability, and Diagnostic Accuracy of the Respiratory Distress Observation Scale for Assessment of Dyspnea in Adult Palliative Care Patients. J Pain Symptom Manage;57(2):304-310.

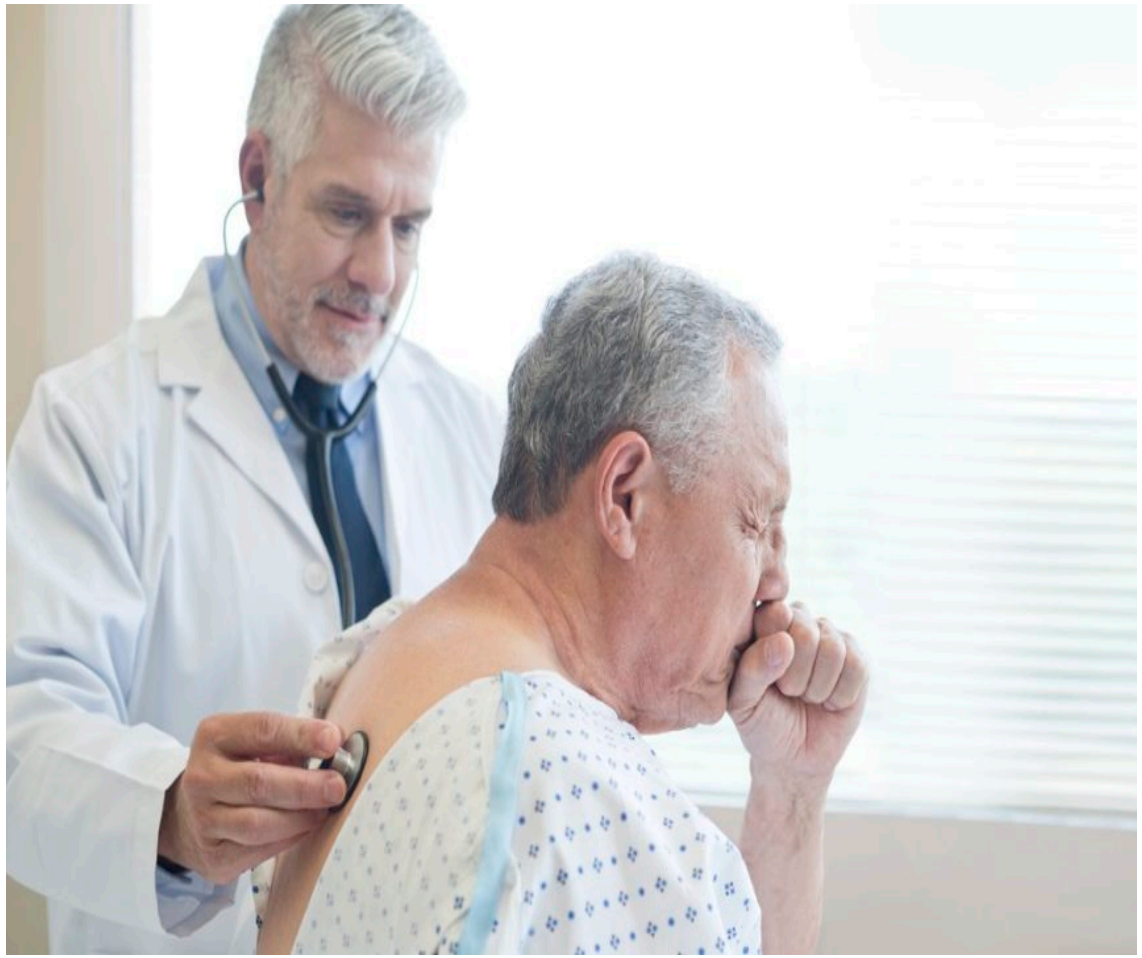
DYSPNEA: GENERAL TREATMENT MEASURES

- Avoid strong odors, fumes, & smoke
- Identify & avoid any triggers
- Positioning (sitting up)
- Increasing air movement via a fan or open window
- Use of bedside relaxation techniques

- ***In the imminently dying patient, discontinuing fluids or feeding is appropriate***

Fast Facts, April 2015

DYSPNEA: NON-PHARMACOLOGIC MANAGEMENT



Multi-disciplinary regimens are most effective for chronic dyspnea

- Disease management
- Anxiety reduction
- Emergency contingent planning
- Self-mastery of breathing mechanics
- Exercise training

DYSPNEA: NON-PHARMACOLOGIC MANAGEMENT

- **Pulmonary rehabilitation**
- **Patient education** including the psych-social-spiritual impact of the dyspnea-anxiety cycle
- **Energy conservation techniques**: reorganizing living spaces to reduce energy expenditure, prioritizing activities within their ability, and utilizing restorative aids such as walkers or canes
- **Cognitive behavioral therapy**: delivered by trained therapists
- **Relaxation techniques**: diaphragmatic and pursed lip breathing training, guided imagery, meditation, and music therapy
- **Acupuncture**

DYSPNEA: PHARMACOLOGIC MANAGEMENT

- **Opioids**: Oral, subcutaneous, and intravenous opioids have long been regarded as the mainstay of pharmacologic treatment for chronic dyspnea
- Opioids appear to be safe and moderately effective at low doses (oral morphine equivalent dose < 30 mg/day) for advanced COPD, interstitial lung disease, and advanced cancer, even when prognosis is anticipated to be several months or years
- ***When utilizing opioids for chronic dyspnea relief, communication is vital to allay concerns amongst the patient, family, and clinicians***

Fast Facts, April 2019

- Extra caution is warranted in patients with sleep apnea and when concomitantly prescribed with benzodiazepines as increased mortality has been noted
- Starting at low doses (e.g. short-acting morphine dose of 0.5-2 mg q4 hours as needed), monitoring for effect, and then titrating up at small intervals until the lowest effective dose is identified, allows for confidence that the treatment is safe and effective
- If tolerated, consider a low dose, once daily, long-acting opioid (e.g. morphine ER 15-30 mg/day)

DYSPNEA: PHARMACOLOGIC MANAGEMENT

- **Benzodiazepines**: A Cochrane systematic review found no convincing evidence for or against the use of benzodiazepines for chronic dyspnea
  - Associated with an increased mortality risk when co-prescribed with opioids
  - Many experts prescribe them for select patients for whom refractory anxiety is a significant component to their symptomatology
- **Antidepressants**: One case series suggested that mirtazapine could benefit select patients with chronic dyspnea
- For associated cough: **Anti-tussives**
- For associated secretions: **Anti-cholinergics**
  - Scopolamine
  - Glycopyrrolate
  - Atropine
- Other agents that may have specific disease modifying effects include diuretics, bronchodilators, and corticosteroids.

DYSPNEA: TREATMENT WITH OXYGEN

Oxygen is often, but not universally, helpful

- Supplemental oxygen in those with hypoxemia have been associated with improved symptom control in appropriate patients with COPD and pulmonary fibrosis
- Therapeutic air by means of a fan to the face has shown benefit for cancer and COPD patients
- In dying patients:
  - When in doubt, a therapeutic trial, based on symptom relief, not pulse oximetry, is indicated
  - Patients generally prefer nasal cannula administration than a mask
  - There is little reason to go beyond 4-6 L/min of oxygen via nasal cannula in the actively dying patient

Fast Facts, April 2019

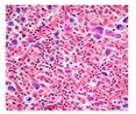
DELIRIUM & AGITATION: ASSESSMENT & MANAGEMENT

PREDISPOSING FACTORS

HEALTHY AGING

Increasing of predisposing factors

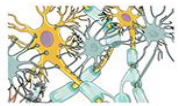
FRAILTY or DEMENTIA



Immunosenescence
Inflammaging

Microvasculature changes

Altered body composition
Oxidative stress



Neuroendocrine dysfunction
Neuroanatomical abnormalities

The lower the burden of predisposing factors, the higher the intensity of the stressor required to cause Delirium

Acute stressors

The higher the burden of predisposing factors, the lower the intensity of the stressor required to cause Delirium

PRECIPITATING FACTORS

DELIRIUM

Impaired neuro-vascular coupling: hypoxia, hypoglycemia

Neuroinflammation

Microglia and Astrocytes activation

Physical and/or psychological stress

Neurostransmitter alterations

Medications

Deteriorating health

POOR HEALTH-RELATED OUTCOMES

Disability
Institutionalization
Hospitalization
Death

Table 1. Diagnostic Criteria for Delirium.

Source of Criteria

DSM-5*

The presence of delirium requires all the criteria to be met:

- Disturbance in attention and awareness
- Disturbance develops acutely and tends to fluctuate in severity
- At least one additional disturbance in cognition
- Disturbances are not better explained by a preexisting dementia
- Disturbances do not occur in the context of a severely reduced level of arousal or coma
- Evidence of an underlying organic cause or causes

Confusion Assessment Method (CAM)†

The presence of delirium requires features 1 and 2 and either 3 or 4:

- Acute change in mental status with a fluctuating course (feature 1)
- Inattention (feature 2)
- Disorganized thinking (feature 3)
- Altered level of consciousness (feature 4)

* The criteria are adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5).[5]
† The criteria are adapted from Inouye et al.[6]

Table 3. Evaluation and Management of Delirium.

Step and Key Issues	Proposed Evaluation and Treatment
Evaluate and treat common modifiable contributors to delirium*	
Drugs	Consider the etiologic role of newly initiated drugs, increased doses, interactions, over-the-counter drugs, and alcohol; consider especially the role of high-risk drugs: lower the dose, discontinue the drug, or substitute a less psychoactive medication
Electrolyte disturbances	Assess for and treat, especially dehydration, sodium imbalance, and thyroid abnormalities
Lack of drugs	Assess possible symptoms of withdrawal from long-term use of sedatives, including alcohol and sleeping pills; assess for and treat poorly controlled pain (lack of analgesia): use local measures and scheduled treatment regimens that minimize the use of opioids (avoid meperidine)
Infection	Evaluate and treat, especially urinary tract, respiratory tract, and soft-tissue infections
Reduced sensory input	Address issues involving vision (e.g., encourage use of eyeglasses) and hearing (e.g., encourage use of hearing aids or a portable amplifier)
Intracranial disorders	Consider such disorders (e.g., infection, hemorrhage, stroke, or tumor) if there are new focal neurologic findings or a suggestive history or if diagnostic evaluation for causes outside the central nervous system is unrevealing
Urinary and fecal disorders	Assess for and treat urinary retention (so-called cystocerebral syndrome) and fecal impaction
Myocardial and pulmonary disorders	Assess for and treat myocardial infarction, arrhythmia, heart failure, hypotension, severe anemia, exacerbation of chronic obstructive pulmonary disease, hypoxia, and hypercarbia
Prevent or manage complications	
Urinary incontinence	Implement a scheduled toileting program
Immobility and falls	Avoid physical restraints; mobilize the patient with assistance; use physical therapy
Pressure ulcers	Mobilize the patient; reposition an immobilized patient frequently and monitor pressure points
Sleep disturbance	Implement a nonpharmacologic sleep-hygiene program, including a nighttime sleep protocol; avoid sedatives; minimize unnecessary awakenings (e.g., for measuring vital signs)
Feeding disorders	Monitor dietary intake; provide feeding assistance if needed, aspiration precautions, and supplementation as necessary
Maintain patient comfort and safety	
Behavioral interventions	Teach hospital staff de-escalation techniques for patients who have hyperactive or agitated delirium; encourage family visitation
Pharmacologic interventions	Use low doses of high-potency antipsychotic agents only if necessary
Restore function	
Hospital environment	Reduce clutter and noise; provide adequate lighting; encourage family to bring in familiar objects from home
Cognitive reconditioning	Staff should reorient patient to time, place, and person at least three times daily
Ability to perform activities of daily living	Use physical and occupational therapy; as delirium clears, match performance to ability
Family education, support, and participation	Provide education about delirium, its causes and reversibility, the best ways to interact with affected patients, and the role of the family in restoring function
Discharge planning and education	Provide increased support for activities of daily living as needed at discharge; teach family members to follow mental status as a barometer of recovery

* The first letters of these eight items form the mnemonic DELIRIUM.

N Engl J Med 2017; 377:1456-1466. DOI: 10.1056/NEJMcp1605501

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Table 4. Multicomponent Nonpharmacologic Approaches to Delirium Prevention

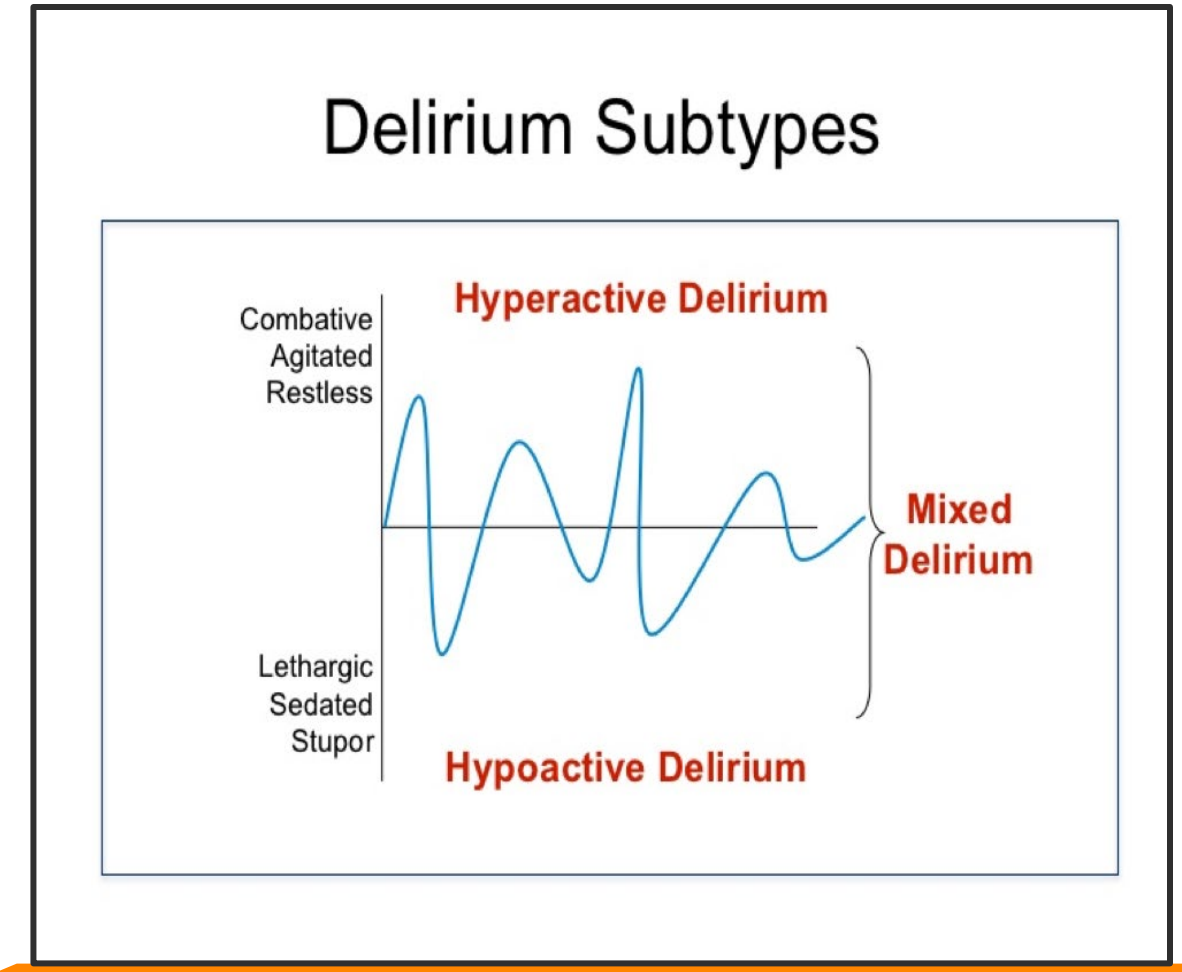
Approach	Description
Orientation and therapeutic activities	Provide lighting, signs, calendars, clocks Reorient the patient to time, place, person, your role Introduce cognitively stimulating activities (eg, reminiscing) Facilitate regular visits from family, friends
Fluid repletion	Encourage patients to drink; consider parenteral fluids if necessary Seek advice regarding fluid balance in patients with comorbidities (heart failure, renal disease)
Early mobilization	Encourage early postoperative mobilization, regular ambulation Keep walking aids (canes, walkers) nearby at all times Encourage all patients to engage in active, range-of-motion exercises
Feeding assistance	Follow general nutrition guidelines and seek advice from dietician as needed Ensure proper fit of dentures
Vision and hearing	Resolve reversible cause of the impairment Ensure working hearing and visual aids are available and used by patients who need them
Sleep enhancement	Avoid medical or nursing procedures during sleep if possible Schedule medications to avoid disturbing sleep Reduce noise at night
Infection prevention	Look for and treat infections Avoid unnecessary catheterization Implement infection-control procedures
Pain management	Assess for pain, especially in patients with communication difficulties Begin and monitor pain management in patients with known or suspected pain
Hypoxia protocol	Assess for hypoxia and oxygen saturation
Psychoactive medication protocol	Review medication list for both types and number of medications

JAMA. 2017;318(12):1161-1174.doi:10.1001/jama.2017.12067

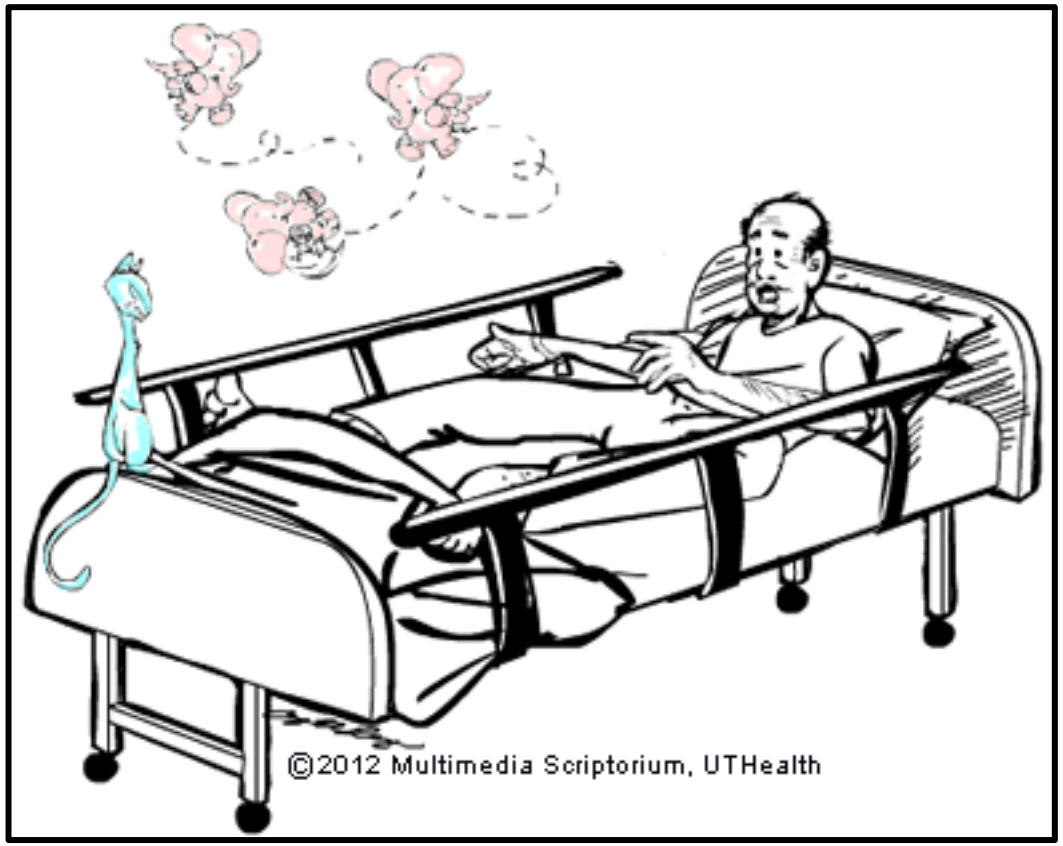
TERMINAL DELIRIUM

Irreversible delirium and agitation at the end-of-life

- End-stage organ failure, imminent death
- Accumulation of toxic metabolites
- An adequate therapeutic trial fails to reverse the delirium at end-of-life
- **Palliative care emergency**
- Common reason for palliative sedation



APPROACH TO TERMINAL DELIRIUM



Reidy J. Delirium. AAHPM Intensive Board Review Course, 2016

Educate and support family and caregivers

- To understand its causes
- Finality and irreversibility
- Management approach

Evaluate and reverse treatable contributing factors

- Pain, urinary retention, constipation

Irreversible, terminal delirium does not respond to conventional treatments for causes of reversible delirium

DELIRIUM: CONSENSUS ON PHARMACOTHERAPY

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- Despite the controversy regarding pharmacotherapy, two areas of consensus seem to remain:

  a. **Hyperactive patients who are a danger to themselves or others (pulling out lines or tubes, striking caregivers, etc) despite behavioral and environmental modification, should be treated pharmacologica**lly.

  - Notably, there is no evidence-based drug approach to this, and reasonable treatment options could include antipsychotics (especially if symptomatology includes hallucinations or delusions), or sedatives such as benzodiazepines or dexmedetomidine if prognosis is felt to be short

  b. **Patients with terminal delirium should be treated pharmacologically if it is the judgment of their caregivers that the delirium is a source of suffering.**

  - In these circumstances, it is important to consider the therapeutic goal in the context of the patient's prognosis
  - If sedation is acceptable, or even the goal in a dying patient, a sedating dose of a benzodiazepine or a sedating antipsychotic such as chlorpromazine is probably a prudent approach even though such medications are known to cloud cognitive clarity

Fast Facts, May 2015

Table 5. Pharmacologic Management of Delirium: Usual Starting Doses*

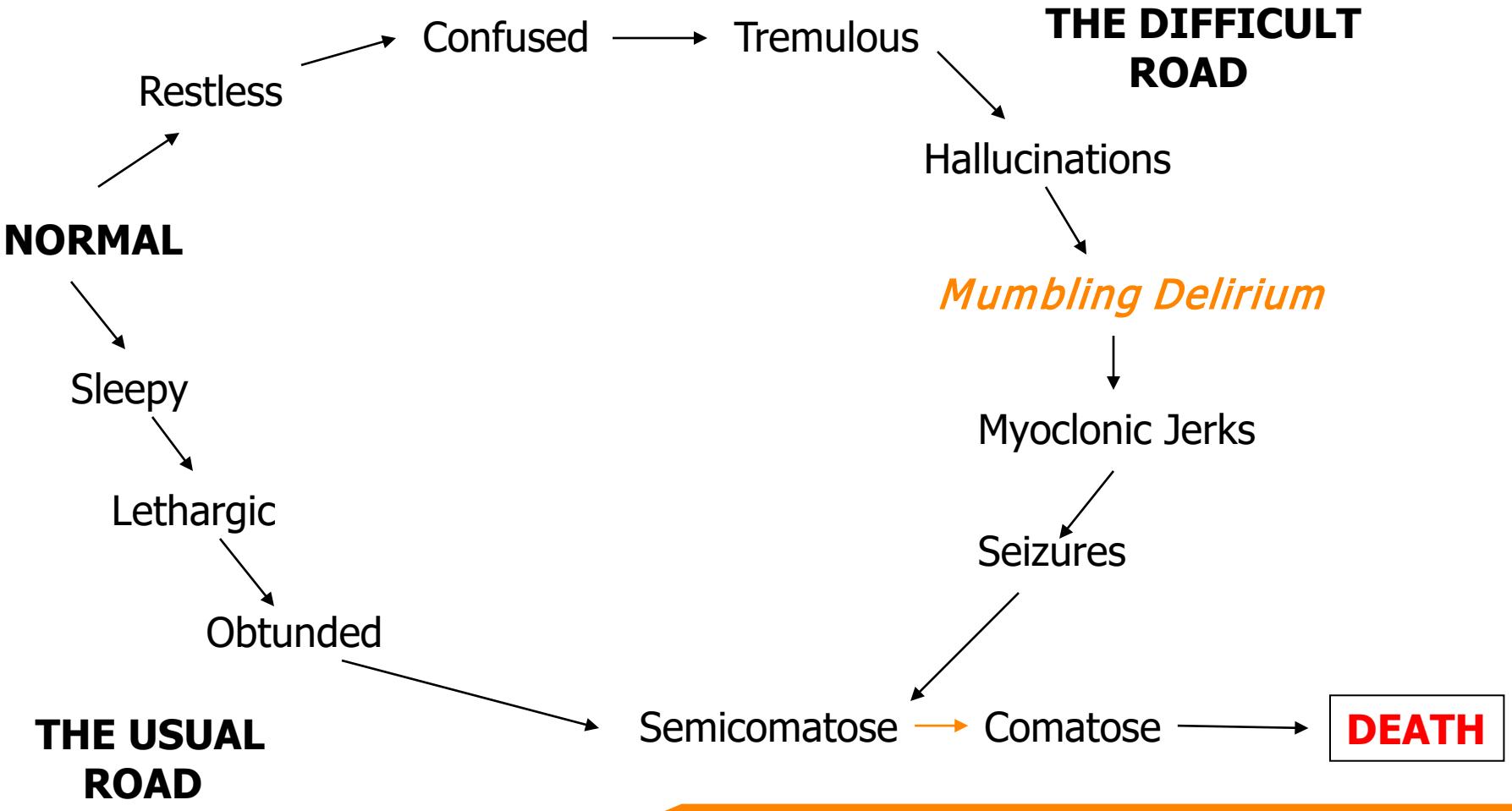
Predominantly neuroleptic effects
- Haloperidol, 0.5–1 mg every 30 minutes orally (0.5–1 mg every 30 minutes subcutaneously or intravenously, titrate to effect, usual maximal dose not to exceed 3 mg/24 hours)
- Olanzapine, 2.5–5 mg orally once daily
- Risperidone, 0.5 mg orally twice daily

Predominantly sedative effects
- Lorezepam, 0.5–1 mg every 4 hours orally, subcutaneously, or intravenously
- Propofol, 10-mg bolus followed by 10 mg/h intravenously
- Midazolam, 1–2 mg/h subcutaneously or intravenously

* Titrate dose to effect in all regimens.

Anesthesiology. 2016 Dec;125(6):1229-1241.

2 ROADS TO DEATH



COMMUNITY PCLC ACTION PERIOD 2: OCTOBER 2021 – JANUARY 2022

PCLC BUNDLE ELEMENT 2: PC POWER PLAN

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Provider and staff training via CAPC modules

Case-based learning during Open Office Hours

Interdisciplinary team (IDT) Palliative Care Plan/ Symptom management orders

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C-PCLC FACILITY - *WORKPLAN*

Facility Name: _____

SECOND ACTION PERIOD — *Palliative Care Power Plan*

Date: _____

Ensure palliative care education and training of facility providers (MD, NP, PA) and staff members, participate in case-based learning, and implement a set of actionable palliative care and treatment guidelines (care plan/ order sets) for identified patients within the cohort that addresses the symptoms and stressors of their illness. ***Please complete and submit to your AHS facilitators before the end of your second action period. (By January 2022)***

What is your team's strategy to implement this initiative in your facility and achieve your stated goals?				
WHAT	**HOW**	**WHO – person/s responsible**	**WHEN**	**Feedback/ Progress Review Process**
1. Facility Providers & Staff Training	• Activate CAPC account for facility and have providers/ staff members register on CAPC and access at least 1 module • 5 facility providers (MD, NP, PA) or staff members per month	• Facility champion to identify 5 facility providers/ staff members per month to access CAPC	• November 2021 • December 2021 • January 2022 • February 2022	• CAPC to track and report monthly on facility engagement - Activation of account - Number of facility providers/ staff members per month - Number of CAPC modules accessed
2. Case-based Learning during Open Office Hours	• Identify and submit 1 case per month for discussion during Open Office Hours • See Case Summary Form attached		• November 2021 • December 2021 • January 2022 • February 2022	• Complete 1 Case Summary Form per month to Community PCLC coordinator, Lauren Salvatore • Any case not discussed during office hours may be scheduled for discussion with Community PCLC Project Director, Dr. Matti-Orozco
3. ☐ IDT Palliative Care Plan, OR	• Engage multidisciplinary team to develop, create and implement an IDT		By January 2022	• Submit either an IDT Palliative Care Plan or a new Symptom Management Order Set
☐ PC Order Set – New Symptom Management, specify: - Pain - Shortness of breath/ dyspnea - Delirium/ agitation	Palliative Care Plan or a new Symptom Management Order Set			

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RECOMMENDED TRAINING ACROSS THE IDT (Recommended refresher courses are denoted with *)

CAPC Course Title	Drivers	Aides	Administrators	Social Work	Nursing	Providers	Therapists, Dietitians
An In-Depth Look at Palliative Care and Its Services	✔	✔	✔	✔	✔	✔	✔
A Palliative Approach to Care for Direct Care Workers*	✔	✔	✔				
Communication Skills							
Delivering Serious News			✔	✔	✔	✔	
Discussing Prognosis			✔	✔	✔	✔	
Clarifying Goals of Care*	✔	✔	✔	✔	✔	✔	✔
Conducting a Family Meeting			✔	✔	✔	✔	✔
Advance Care Planning Conversations*			✔	✔	✔	✔	
Building Skills in Basic Advance Care Planning							
Basic Advance Care Planning: Introduce and Motivate				✔	✔	✔	
Basic Advance Care Planning: Guide and Document				✔	✔	✔	
Beyond Conversation: Integrating Basic Advance Care Planning into Practice				✔	✔	✔	

RECOMMENDED CAPC MODULES

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CAPC Course Title	Drivers	Aides	Administrators	Social Work	Nursing	Providers	Therapists, Dietitians
Symptom Management, Preventing Crises, and Relief of Suffering Across the Disease Trajectory							
Comprehensive Pain Assessment*	✔	✔	✔	✔	✔	✔	✔
Reducing Risks for Older Adults	✔	✔	✔	✔	✔	✔	✔
Relieving Suffering in Patients with Dementia and Their Caregivers	✔	✔	✔	✔	✔	✔	✔
Critical Decisions in Advanced Dementia*				✔	✔	✔	
Relieving Suffering in Patients with COPD				✔	✔	✔	
Relieving Suffering in Patients with Heart Failure				✔	✔	✔	

SAMPLE: IDT PALLIATIVE CARE PLAN

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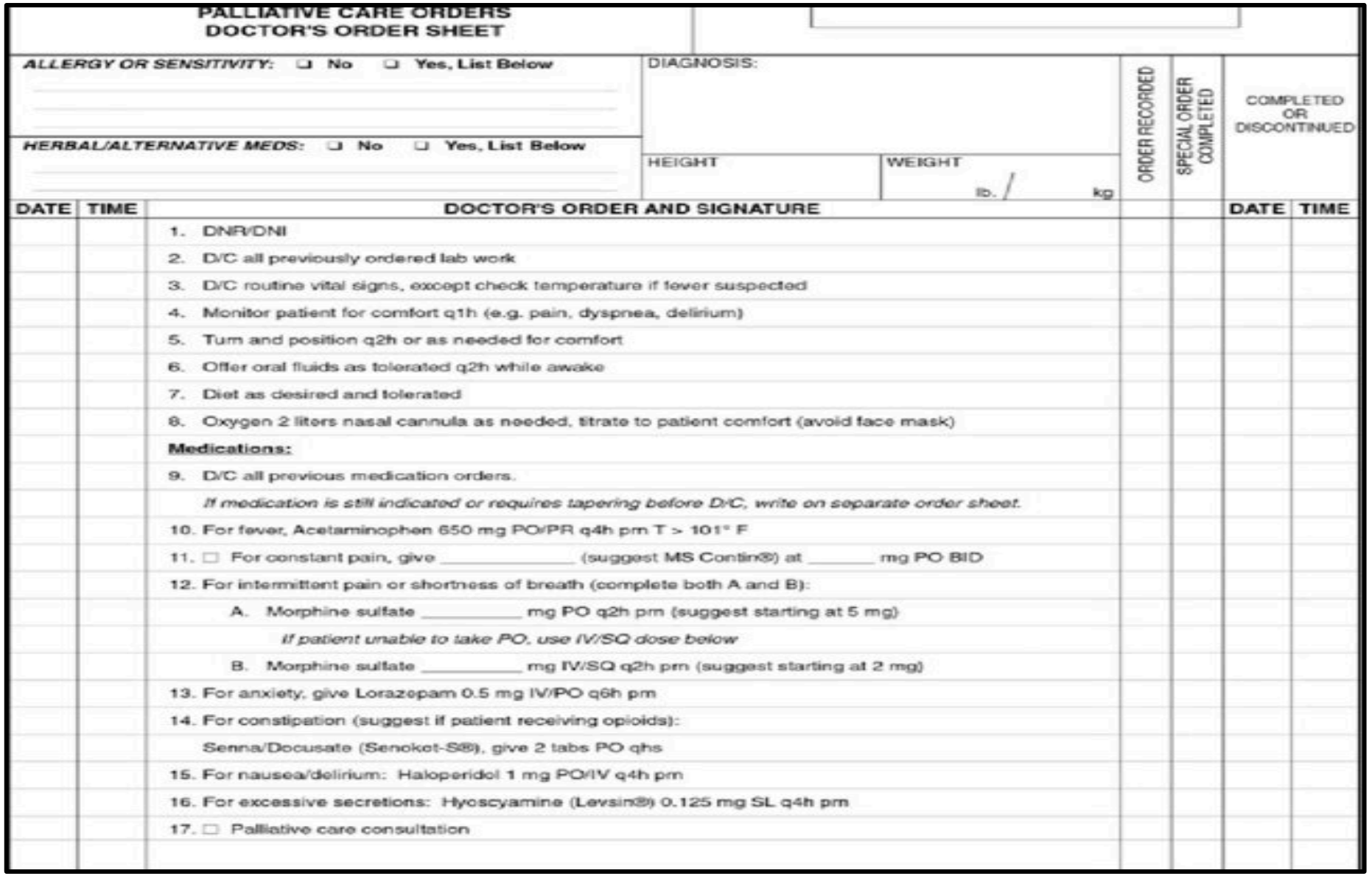
Please initial each subject to indicate you have addressed, reviewed, and implemented intervention during your home visit with the patient	
Basic Assessment Needs	____ Review and update Advance Directive and DNR
	____ Review Hospice Philosophy
	____ Review 4 levels of care. Ascertain preferred place of death
	____ Review call system/Triage. How to contact Hospice 24-hours day. Discuss use of 911 versus calls to Hospice
	____ Continue instructions in funeral planning and what to do when patient dies
	____ Assess for immediate need for other visits, (i.e., MSW, Chaplain, CHHA, M.D.)
	____ Review signs and symptoms of death and dying
	____ Discuss home safety
	____ Consider increased frequency of visits for each discipline
	____ Communicate Plan of Care to team members including Triage as needed
Medications	____ Syringe for sublingual meds
	____ Anticipate for congestion; consider Atropine/Levsin
	____ Consider Tylenol supp. For fever
	____ Instructed on sublingual/rectal administration of meds
	____ Red sticker on Kaiser card for pharmacy
	____ Discussed medication side effects
Equipment Needs	____ Consider hospital bed, commode, over bed table, wheelchair
	____ Anticipate needs for diapers, chux, syringes, toothettes, urinal, bedpan, etc.
	____ Educated/evaluated the use of oxygen and safety precautions
Psychosocial Needs	____ Assessed for coping mechanism
	____ Addressed for possible unfinished issues with family/patient, financial/legal
	____ Assessed for increase social worker intervention through visits, telephone calls
	____ Assessed for cultural beliefs & values, beliefs about death and dying
	____ Assessed for caregiver status
	____ Bereavement risk

Pain Management	____ Assessed disease process and reviewed pain management
	____ Instructed patient/family route of medication (sub-lingual/rectal) - Syringe provided
	____ Instructed regarding frequency of meds, adjusting dosage for patients comfort and what meds to use
	____ Check for adequate supply of pain meds in the home
Constipation	____ Instructed/reviewed bowel regimen
	____ Checked patient for fecal impaction if indicated
	____ Ordered Ducolax supp, fleet enema as needed
Urinary	____ Assessed when patient last voided – retention
	____ Anticipated for foley catheter need
Skin Integrity	____ Instructed re: skin care, bed repositioning, changing diapers, safety, lotion to bony prominence
	____ Oral hygiene care
Anxiety/Pre-terminal Agitation	____ Assessed patient for hallucination – educate family / caregiver as needed
	____ Reviewed medication management, consider Xanax, if Xanax not effective, assess for Thorazine
	____ Assessed for music therapy
Spiritual Needs	____ Addressed spiritual status/needs, may need to contact patients clergy or pastor as requested
Educational Needs/Materials	____ Provided patient education materials
	____ Reviewed disease pathophysiology
	____ Instructed patient/family on self management skills
	____ Instructed patient/family about soft music, massage, aromatherapy, candles, pets, etc. _____
Signature/Title _____ Initial/Date_____	



PALLIATIVE CARE ORDERS
DOCTOR'S ORDER SHEET

ALLERGY OR SENSITIVITY: ❑ No ❑ Yes, List Below

HERBAL/ALTERNATIVE MEDS: ❑ No ❑ Yes, List Below

DIAGNOSIS:

HEIGHT

WEIGHT lb. / kg

DATE	TIME	DOCTOR'S ORDER AND SIGNATURE	ORDER RECORDED	SPECIAL ORDER COMPLETED	COMPLETED OR DISCONTINUED DATE	COMPLETED OR DISCONTINUED TIME
		1. DNR/DNI				
		2. D/C all previously ordered lab work				
		3. D/C routine vital signs, except check temperature if fever suspected				
		4. Monitor patient for comfort q1h (e.g. pain, dyspnea, delirium)				
		5. Turn and position q2h or as needed for comfort				
		6. Offer oral fluids as tolerated q2h while awake				
		7. Diet as desired and tolerated				
		8. Oxygen 2 liters nasal cannula as needed, titrate to patient comfort (avoid face mask)				
		Medications:				
		9. D/C all previous medication orders.				
		If medication is still indicated or requires tapering before D/C, write on separate order sheet.				
		10. For fever, Acetaminophen 650 mg PO/PR q4h prn T > 101° F				
		11. ☐ For constant pain, give _____ (suggest MS Contin®) at _____ mg PO BID				
		12. For intermittent pain or shortness of breath (complete both A and B):				
		A. Morphine sulfate _____ mg PO q2h prn (suggest starting at 5 mg)				
		If patient unable to take PO, use IV/SQ dose below				
		B. Morphine sulfate _____ mg IV/SQ q2h prn (suggest starting at 2 mg)				
		13. For anxiety, give Lorazepam 0.5 mg IV/PO q6h prn				
		14. For constipation (suggest if patient receiving opioids):				
		Senna/Docusate (Senokot-S®), give 2 tabs PO qhs				
		15. For nausea/delirium: Haloperidol 1 mg PO/IV q4h prn				
		16. For excessive secretions: Hyoscyamine (Levsin®) 0.125 mg SL q4h prn				
		17. ☐ Palliative care consultation				

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THANK YOU! QUESTIONS? COMMENTS?