TRANSITION TO COMFORT

- Review plan and expectation with patient of family/surrogate regarding comfort care.
- Discontinue therapies unrelated to comfort promotion including antibiotic and insulin orders, hemodialysis, EEG, labs, fingersticks, artificial nutrition, IVF, telemetry, radiology.
- Do NOT remove foley catheter.
- Continue scheduled benzodiazepines and ketamine.
- Ensure DNR/DNI/Comfort Care order in Cerner.
- Place magnet over AICD if applicable.
- Contact family and allow communication with patient (this will be case specific and may include medical staff holding phone to patient’s ear, video call in or outside of room, actual visit).
- Offer chaplain services (at x 5114 or x 5329) for patient and family (this could be a visit outside of room, dedicated prayers, a spiritual support call to family).
- Review any nursing concerns about weaning plan.
- Notify consultants of plan for comfort care plan.
- Notify Palliative Medicine or Geriatrics as needed.

MEDICATE WITH AN OPIOID AND A BENZODIAZEPINE

**OPIOIDS** are the standard of care to treat dyspnea/tachypnea/work of breathing in addition to pain.
- Supplemental oxygen is not a comfort measure. Supplemental oxygen can be used to support an awake patient with O2 sat < 90%; otherwise wean off HFNC or masks to O2 sat ≥ 90% and use opioid to treat dyspnea and work of breathing.

**If death is imminent** (minutes to a few hours):
- For opioid naive patients or patients receiving occasional PRN opioids starting regimens may include:
  - MORPHINE: 4mg IV q4hrs scheduled ATC and morphine 4mg IV q1hr PRN. If dose insufficient, increase scheduled and PRN doses by 100%.
  - HYDROMORPHONE: 1mg IV q4hrs scheduled ATC and hydromorphone 1 IV q1hr PRN. If dose insufficient, increase scheduled and PRN doses by 100%.
- For patients with opioid use over the last 24 hours, total amount of IV opioid use over the last 24 hours (make sure all meds converted to IV dosing), divide by 6, and schedule this dose every 4 hours ATC. Also order 100% of this dose for q1hr PRN dose.
- Ensure PRN indication is for “pain/dyspnea/tachypnea/increased work of breathing.”

**If death is expected in more than a few hours** AACA may be initiated with **Palliative Medicine approval** 8a-6p or next AM:
- For opioid naive patients or patients receiving occasional PRN opioids starting regimens may include:
  - MORPHINE: morphine AACA settings: basal rate 5mg per hour; bolus demand dose 5mg; lockout 10 minutes.
  - HYDROMORPHONE: hydromorphone AACA settings: basal rate 1mg per hour; bolus demand dose 1mg; lockout 10 minutes.
- For patients with opioid use over the last 24 hours, total IV opioid use over the last 24 hours (make sure all meds converted to IV dosing), divide by 24, and use this dose as the basal rate and bolus demand dose.
- For patients already requiring complex or high dose opioid regimens, please contact Palliative Medicine or Geriatrics for symptom guidance at x 4337 or by TigerConnect roles.
- BENZODIAZEPINE can treat agitation/ restlessness and provide sedation during distress.
- For patients not already on standing benzodiazepines a starting regimen may include LORAZEPAM 1-2mg IV q2hr PRN anxiety/restlessness.

TITRATE MEDICATIONS FOR COMFORT

- Titrater opioid to respiratory rate < 25, ensure no increased work of breathing such as use of accessory muscles of respiration, no grimacing/moaning.
- For a patient on scheduled and PRN opioid pushes; if dose is insufficient, increase scheduled and PRN doses by 100%.
- For a patient on opioid AACA, if using >3 demand boluses in 8 hours, increase rate by 25% and match demand bolus dose to new basal rate. If using >6 demand boluses in 8 hours, increase basal rate by 50% and match demand bolus dose to new basal rate.
- If a PRN dose of benzodiazepine is insufficient, increase the dose by 100%.
- For frequent use of benzodiazepine, schedule dose q4hr ATC and continue PRN.

MANAGE ADDITIONAL SYMPTOMS

- Secretions: Most effective approach is lateral positioning of the patient. Please note that “gurgling” or “rattling” is not uncomfortable for the patient and does not require medication. If medications are necessary to help limit choking, consider glycopyrrolate 0.4mg IV q4hr PRN copious secretions OR scopolamine TD q72hr which can take more than 12 hours to take effect.
- Nausea and vomiting: Regimens may include PRN or scheduled: Ondansetron 8mg IV q6hr; Metoclopramide 5-10mg IV q6hr; or, Haloperidol 1mg IV q4hr.
- Agitation: Regimens may include Haloperidol 1-2mg IV q2hr PRN; may schedule q4-6hr if needed.
- If IV access is lost or suggested medications are unavailable OR if patient symptoms are inadequately controlled, please contact Palliative Medicine or Geriatrics for further guidance at x 4337 or by TigerConnect roles.