

Form Title **C2 Medication and Care, Adult - All Locations Order Set**

Form Number **21097Bond**

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Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

C2 Medication and Care, Adult All Locations Order Set

Select orders by placing a (✓) in the associated box

Note: This order set is to be used in conjunction with the Care of the Imminently Dying Pathway Instructions, Initial Care Needs Assessment, and Nursing Symptom and Care Assessment and Documentation.

Admit		
<input checked="" type="checkbox"/> Admit to: Most Responsible Health Practitioner (MRHP) <i>(in non-acute care settings, identify MRHP)</i>		
Diagnosis _____		
Patient Care		
<input checked="" type="checkbox"/> Clinical Communication: Patient has a C2 Goals of Care Designation Order <i>(see completed Green Sleeve)</i> .		
<input checked="" type="checkbox"/> Discontinue: previously scheduled laboratory and diagnostic investigations.		
<input checked="" type="checkbox"/> Clinical Communication: cancel any scheduled appointments.		
<input type="checkbox"/> Clinical Communication: Deactivate ICD (Implantable Cardioverter Defibrillator) as discussed with Patient/Alternate Decision Maker (ADM).		
<input checked="" type="checkbox"/> Foley Catheter: Insert PRN, only as needed for urinary retention or patient comfort, <input checked="" type="checkbox"/> lidocaine 2% gel, apply intra-urethral once PRN, for foley catheter insertion.		
<input checked="" type="checkbox"/> Notify: MRHP if symptoms are not well managed with current care and medication.		
Activity		
<input checked="" type="checkbox"/> Activity as tolerated		
Monitoring		
<input checked="" type="checkbox"/> Discontinue: vital signs including oximetry		
Diet		
<i>As tolerated for comfort, as discussed with Patient/ADM for potential aspiration risk.</i>		
<input type="checkbox"/> Regular Diet		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Clinical Communication: May have oral fluids and ice chips for comfort.		
Hydration/Fluids		
<input type="checkbox"/> 0.9% NaCl infusion Hypodermoclysis (HDC) SUBCUTANEOUSLY at _____ mL/hour .		
Respiratory Care		
<input type="checkbox"/> Clinical Communication: Oxygen not required.		
OR		
<input type="checkbox"/> Oxygen Therapy - Current oxygen needs for patient comfort are _____ L/min via _____		
<input type="checkbox"/> Clinical Communication - Provide fan for dyspnea following organization's infection control practice guidelines.		
Medications		
<i>Review ALL previous medication orders including diabetic management AND discontinue medications that are NOT related to symptom management</i>		
<input checked="" type="checkbox"/> Subcutaneous Cannula – Insert only as needed for administration of subcutaneous medications.		
Prescriber Signature	Date <i>(dd-Mon-yyyy)</i>	Time <i>(hh:mm)</i>

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Medication continued

For comfort

- artificial saliva gel TOPICALLY to oral mucous membrane QID for dry mouth.
- artificial saliva gel TOPICALLY to oral mucous membrane every 1 hour as needed (PRN) for dry mouth.
- hydroxypropylmethylcellulose 0.5% eye drops, 1 drop to each eye every 1 hour PRN while awake for dry eyes.
- macrogol – propylene glycol (SECARIS®) gel INTRANASALLY to both nostrils every 4 hours PRN for dry nares.
- acetaminophen suppository 650 mg RECTALLY every 4 hours PRN for symptomatic fever or mild discomfort.

For pain and/or dyspnea

Review patient's current opioid history

- opioid *(complete medication name, dose, route, frequency):*

- opioid *(complete medication name, dose, route, frequency):*

IF no history of regular opioid use in the past four weeks:

- morphine 2.5 mg SUBCUTANEOUSLY every 1 hour PRN for pain and/or dyspnea.
Notify MRHP if patient receives more than 3 morphine doses in 8 hours.
- morphine 2.5 mg SUBCUTANEOUSLY every 6 hours for pain and/or dyspnea.

OR

- HYDROMorphone 0.5 mg SUBCUTANEOUSLY every 1 hour PRN for pain and/or dyspnea.
Notify MRHP if patient requires more than 3 HYDROMorphone doses in 8 hours.
- HYDROMorphone 0.5 mg SUBCUTANEOUSLY every 6 hours for pain and/or dyspnea.

For nausea and/or vomiting

- metoclopramide 10 mg SUBCUTANEOUSLY every 1 hour PRN for nausea and/or vomiting.
Notify MRHP if patient requires more than 3 metoclopramide doses in 8 hours.

AND/OR

- metoclopramide 10 mg SUBCUTANEOUSLY every 6 hours for nausea and/or vomiting.

OR

- haloperidol 1 mg SUBCUTANEOUSLY every 1 hour PRN for nausea and/or vomiting.
Notify MRHP if patient requires more than 3 haloperidol doses for nausea/vomiting and/or agitation in 8 hours.

For agitation

- haloperidol 1 mg SUBCUTANEOUSLY every 1 hour PRN for agitation. Notify MRHP if haloperidol is ineffective after 3 consecutive doses, or if patient receives more than 3 doses for nausea/vomiting and/or agitation in 8 hours.

IF extreme agitation:

- methotrimeprazine (NOZINAN®) 12.5 mg SUBCUTANEOUSLY every 1 hour PRN for extreme agitation.
Notify MRHP if methotrimeprazine is ineffective after 3 consecutive doses.

Prescriber Signature	Date <i>(dd-Mon-yyyy)</i>	Time <i>(hh:mm)</i>
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Medications continued		
For distressing respiratory secretions		
<input checked="" type="checkbox"/> Clinical Communication: Review parenteral hydration with patient/ADM and MRHP		
Choose one →	}	<input type="checkbox"/> glycopyrrolate 0.4 mg SUBCUTANEOUSLY every 1 hour PRN for distressing respiratory secretions (less sedating effects).
		<input type="checkbox"/> scopolamine hydrobromide 0.4 mg SUBCUTANEOUSLY every 1 hour PRN for distressing respiratory secretions.
		<input type="checkbox"/> atropine 1% ophthalmic drops, apply 2 drops BUCCALLY every 1 hour PRN for distressing respiratory secretions.
For urgent symptoms		
<input type="checkbox"/> midazolam 5 mg SUBCUTANEOUSLY 1 dose PRN and then midazolam 5 mg SUBCUTANEOUSLY every 5 minutes PRN for refractory active seizure greater than 2 minutes and/or massive distressing hemorrhage. Notify MRHP if midazolam is ineffective after 3 consecutive doses.		
Consults and Referrals		
<input type="checkbox"/> Consult Palliative Care for complex symptom management and support.		
Other Orders <i>(For medication orders include: complete medication name, dose, route, frequency):</i>		
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
Discontinue the following:		
<i>Review ALL previous medication orders including diabetic management AND discontinue medications that are NOT related to symptom management</i>		
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
<input type="checkbox"/>	_____	
Prescriber Signature	Date <i>(dd-Mon-yyyy)</i>	Time <i>(hh:mm)</i>