BEACON PROJECT

Comfort Care Order Set (CCOS)

Implementation Plan

Comfort Care Order Set

A) Purpose

Comfort Care Order Set (CCOS) has been developed to improve the processes of care for veterans at end-of-life or dying both in the acute care wards and CLCs (nursing homes) of VA Medical Centers. Care of the dying in inpatient settings is an important aspect of improving care in the hospital in general and improving care for hospice and palliative care patients at Life's End. In the US approximately 3 out of 4 people who die each year are in institutional settings; about 50% of all deaths occur in acute care hospitals and about 25% in occur nursing homes. Although hospice is widely available, the number of deaths each year in the home remains a minority. The reasons for this are variable but include: patient/family preference for death outside the home, difficulty managing personal care in the home by lay caregivers, emotional, social and spiritual distress that complicates in-home care, and the out of pocket cost of care of the dying in the home including lost wages from time missed from work as well as the cost of paid non-family caregivers. Although, effort to extend and improve support for hospice care in the home is important, it should be coupled with efforts to improve the care of patients dying in acute care and CLC units, since it is unlikely that all or even most of these patients could be transferred to home hospice care.

Research has demonstrated that end-of-life care in acute care and nursing home settings often is associated with unmet needs such as: pain and non-pain symptom control, emotional, social and spiritual distress for both the patient and family. In addition to inadequate symptom recognition and management, iatrogenic suffering frequently results from complications, pain and distress related to routine medical care; such as IV infusions, other medications, blood work, testing and monitoring that often are no longer of benefit for the dying patient but instead adds to the pain and suffering at end-of-life. The CCOS has been carefully devised, based on best practices of care for the dying in home hospice. The CCOS guides clinicians to change the processes of care and insure the access to medications for symptom control. This is coupled with changes in all aspects of nursing and personal care to individualize care plans that take advantage of the resources of institutional care. When appropriate disease managing therapies can be continued while at the same time reducing restrictions, avoiding testing and treatments when the burdens now outweighing the benefits while shifting to a CCOS approach. Adopting the CCOS can enhance both the quality and quantity of life for our patients.

B) Testing

CCOS has been extensively tested and evaluated. First the components of the CCOS were compared with the practices and recommendations for provision of care for the dying patient in home settings. Secondly each component was evaluated individually in regards to effectiveness, safety and application for individual physical symptoms considered separately from the totality of care of the patients at end-of-life. For example, the management of delirium with both treatment of and elimination of underlying causes such as constipation, oral hydration and inappropriate medication, coupled with non-pharmacological management and appropriate dosing of low dose anti-psychotic medications. Each of the interventions was evaluated individually in this way.

CCOS were tested for practical application at the Birmingham VAMC by evaluating the process of care for patients who died in the VAMC before and after the implementation of the CCOS. (See attached publication for details of the findings regarding CCOS) Examples of positive impacts on the process of care include a marked increase in the number of patients for whom an opioid was ordered, as well as an increase in the number of veterans who received some opioids in the last 72 hours of life (from 13-72%), as well as non-pharmacological effects such as increase in documented goals of care, family present with patient at time of death, reduction of deaths in the ICU setting and instrumentation.

The practical application of the CCOS was evaluated by observing medical providers using the CCOS. Modifications to improve ease of use and to encourage integration of the entire packet of the CCOS into care plans were made.

Review and observation of the care provided by nurses, pharmacist, respiratory therapist, dietary and all other providers in the hospital who were involved with provision of care for the dying patient was used to understand how they interpreted the CCOS in relation to their provision of care. The barriers and concerns indentified by the front line caregivers input were incorporated into modifications, deletion, and additions to the CCOS to improve the efficacy. This work also leads our understanding of the importance of not only changing the orders for the processes of care but also changing the cultural of the facility. Educating and obtaining buy in from the medical providers who order the CCOS as well as those who will be implementing it is key to making provision of excellent end-of-life care the default position and not the lucky accident.

Subsequently the CCOS system has been installed and tested at 6 other VA Medical Centers in the Southeast. At this time the BEACON Project is developing an implementation packet to support the installation of CCOS into CPRS systems, education and training of clinicians and patent care staff in use of the CCOS and ongoing quality improvement in all impatient setting in the VAH.

The BEACON team has published two articles that relate directly to the development and testing of the CCOS. PDF's of these articles are provided in the appendix of this CCOS Implementation Packet.

C) Practical Application

The CCOS can be used to place orders by both the PCCT clinicians as well as all clinicians with order writing privileges. The PCCT and other clinicians may use part or all of the CCOS. In addition the PPCT may use the order set to initiate palliative care while the patient remains in their current bed section or when admitting or transferring a patient to the Hospice/Palliative Care service.

1. The CCOS can be used to place orders for any patient in an impatient Acute Care Ward, ICU, or CLC. All clinicians who are authorized to write orders with CPRS at your VAMC may want to use some or all of the orders from the CCOS.

2. The CCOS does not require that any other orders be discontinued and can be layered onto existing disease modifying orders for an individual patient that so the overall care plan aligns with the patient's goals of care.

3. The most frequent users of the CCOS have been Palliative Care Consult Teams. The PCCT may use the orders to initiate symptom control for a consult while the patient continues to be admitted the current service. In this situation the CCOS is often a teaching tool to educate the non-Palliative Care Provider about symptom management. Some non-palliative care providers may decide to use parts of the CCOS to assist them with setting up a symptom control care plan independent of the PCCT and/or before the PCCT can see the patient in consult.

4. The PCCT often uses the CCOS to admit or transfer patients to their service.

5. Providers may want to open the CCOS to use one of the components, such as the section for constipation, and not go through the whole CCOS because they already have used the CCOS earlier to set up a care plan and are refining the plan. Others may want to use only a section such as delirium, to quickly address this problem for a patient in the ICU or some other setting.

6. It is always good practice to review all medications and orders on a regular basis to have reconciliation of the evolving goals of care, care plans and the current orders.

D. Components

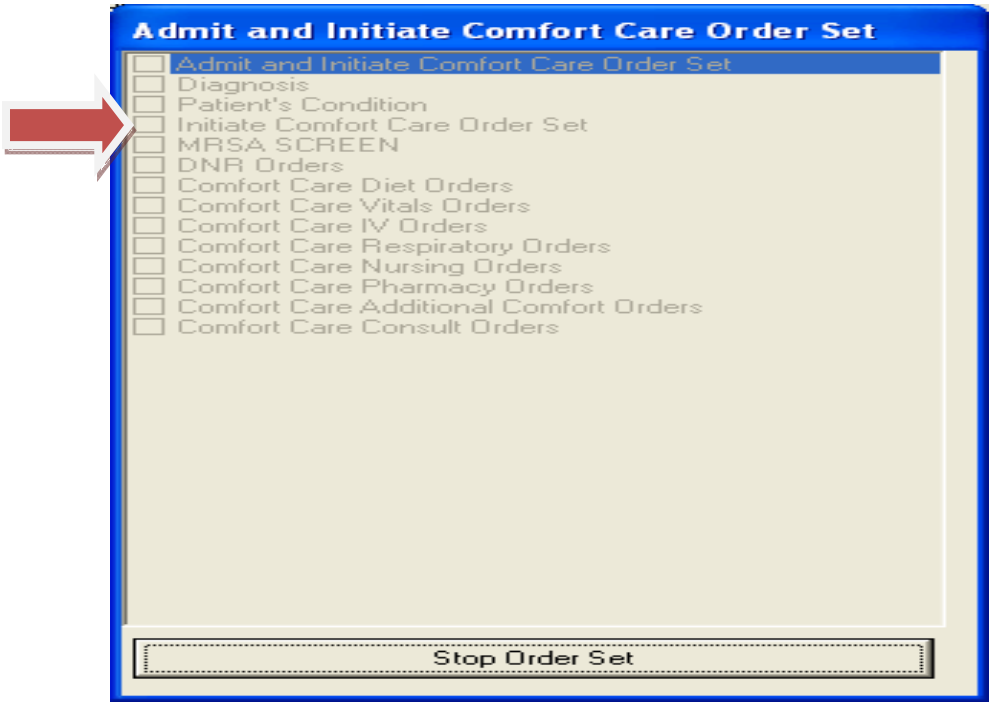
1. Initiate CCOS as part of the plan of care in any location in the VA medical center and can be used by any clinician with authority to place orders.
2. The CCOS does not require that any specific disease modifying treatments or other parts of the plan of care, (such as change in resuscitation status to DNAR). The CCOS is potentially complimentary to the current treatment plan.
3. The CCOS is a decision support tool with education and explanatory notes at each section of the orders to assist the provider in using the CCOS. This includes guidance to consider the burdens and benefits of all interventions and orders including both those in the CCOS and those already in use. Treatment and care plans should be continually modified and updated to reflect the current needs of patients and families
4. CCOS may be imbedded into admission/transfer orders for hospice and palliative care unit or service.

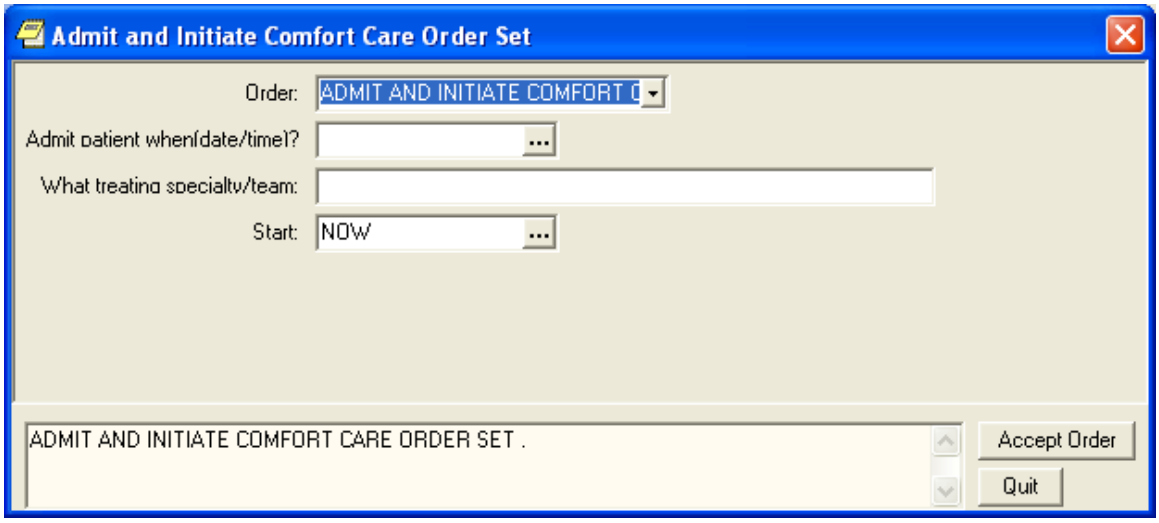
E. Individual Sections

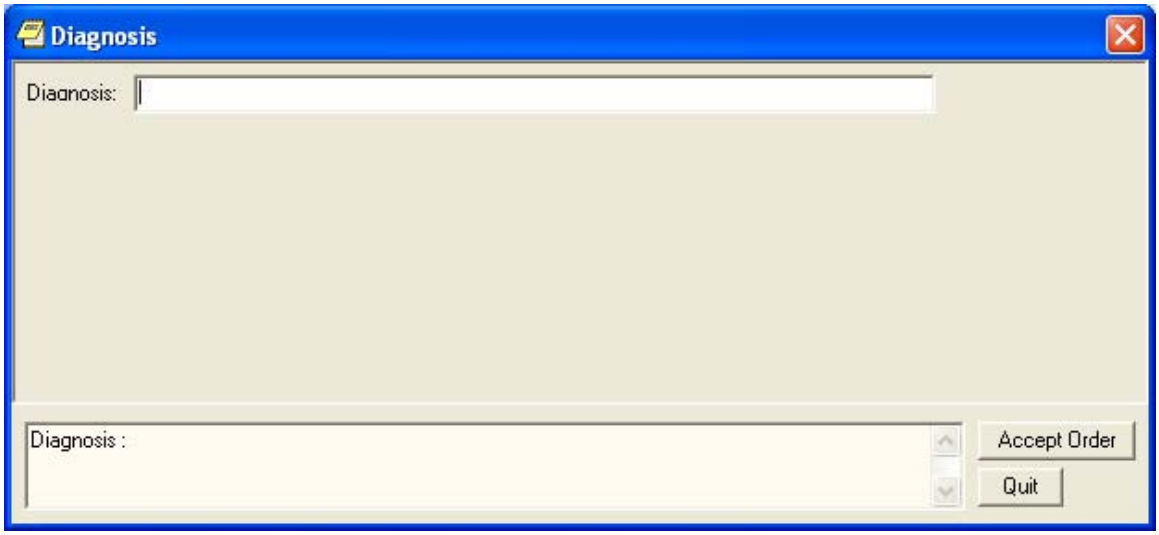
## 1. Admit & Initiate Comfort Care Order Set

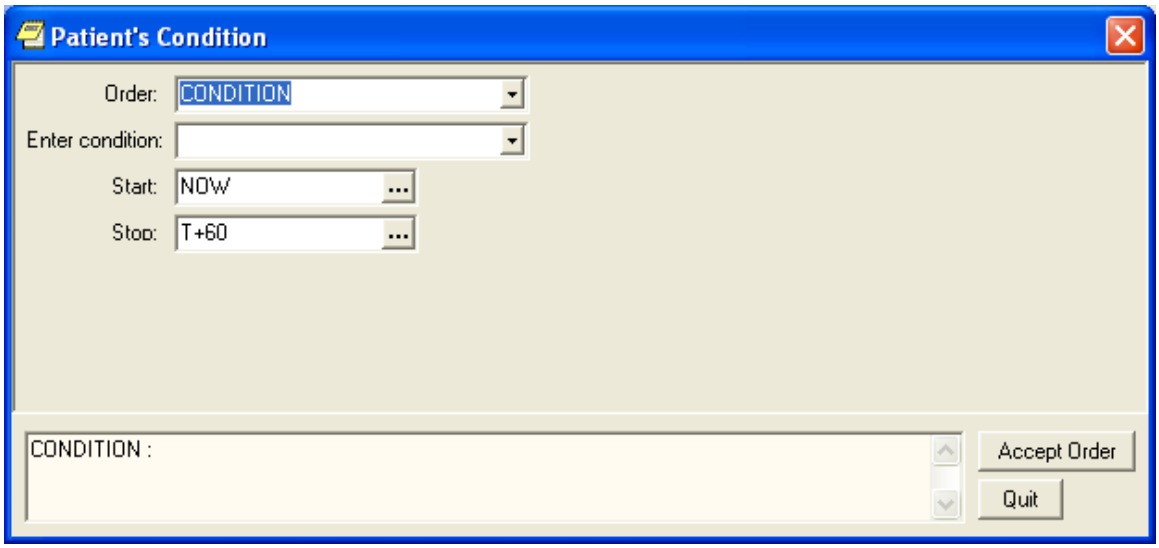
Example of the Admit and Initiate Comfort Care Order Set

A) Initiate CCOS as part of the plan of care in any location in the VA medical center and can be used by any clinician with authority to place orders.
B) If the patient is remaining in the current ward and bed section you would start with Initiate Comfort Care Order Set. See the arrow below)
C) The CCOS does not require that any specific disease modifying treatments or other parts of the plan of care, such as resuscitation change. The CCOS is potential complimentary to the current treatment plan.

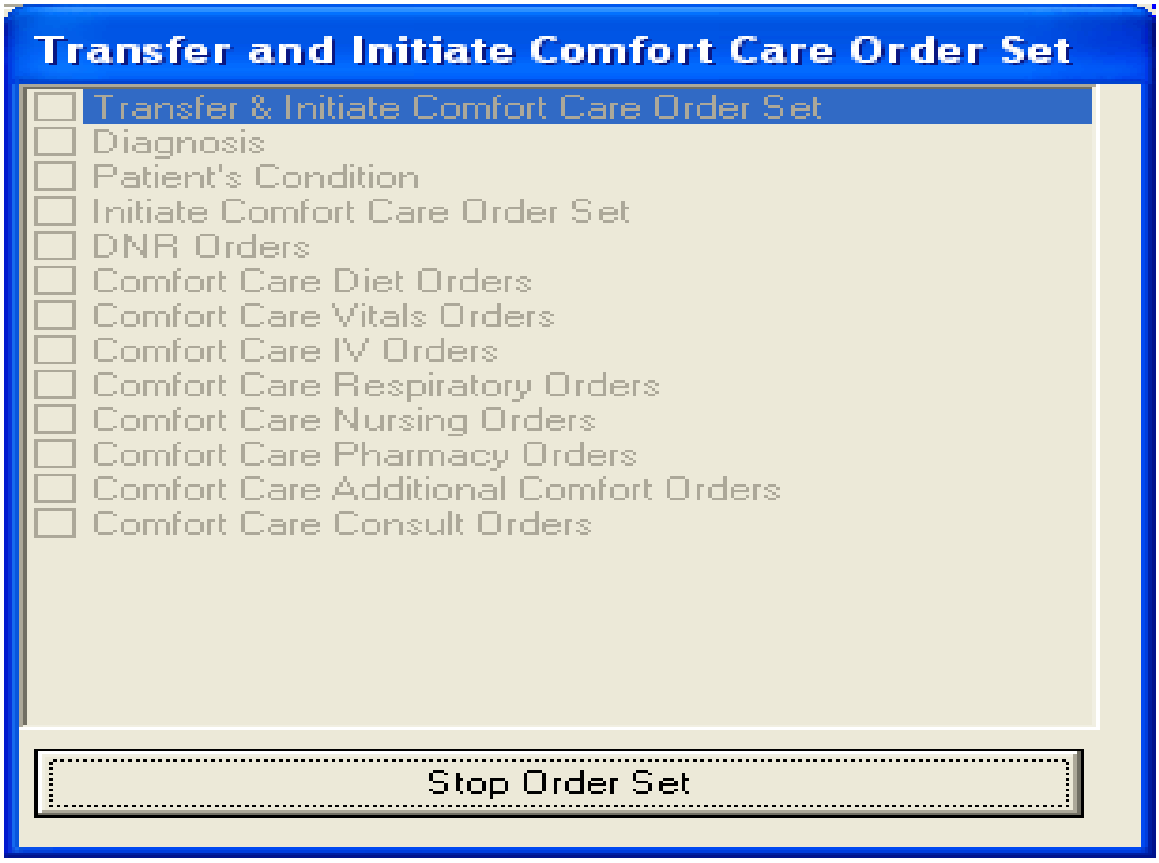


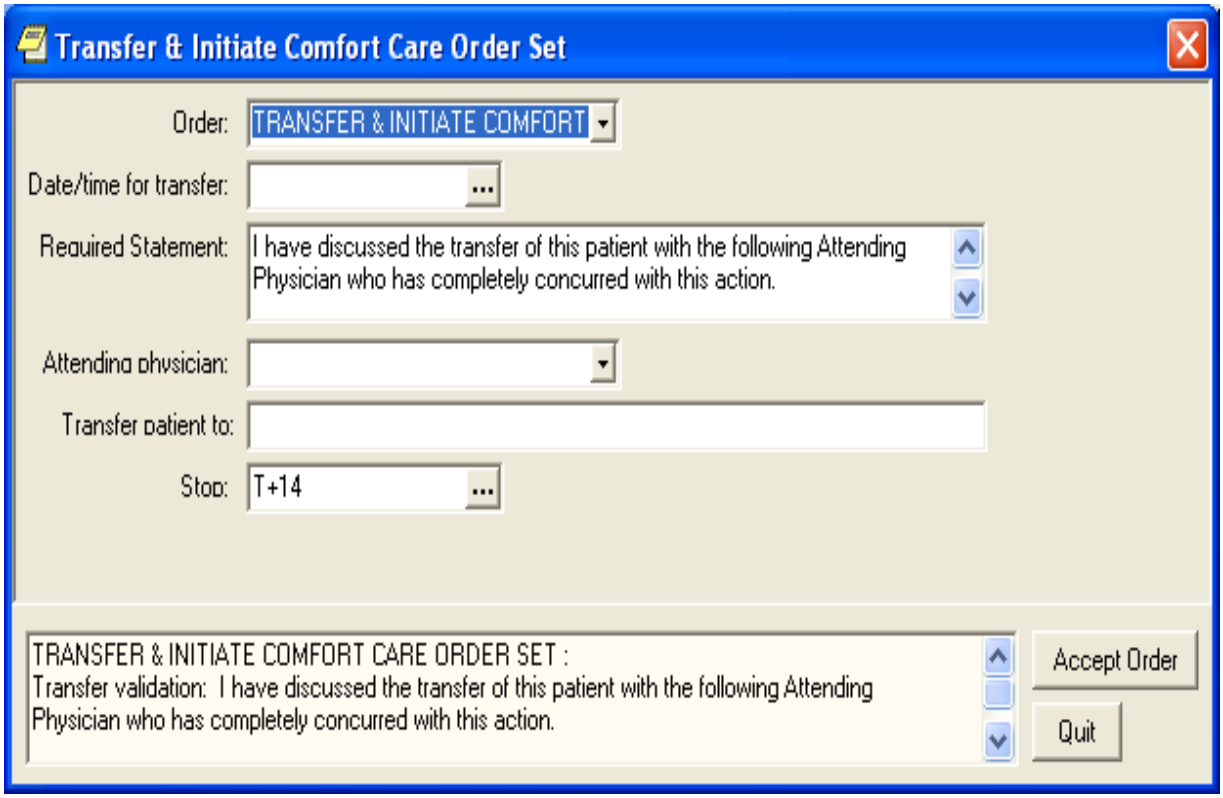

Admit and Initiate Comfort Care Order Set
Order:
ADMIT AND INITIATE COMFORT C
Admit patient when(date/time)?
What treating specialty/team:
Start:
NOW
ADMIT AND INITIATE COMFORT CARE ORDER SET .
Accept Order
Quit


Diagnosis
Diagnosis:
Diagnosis :
Accept Order
Quit


Patient's Condition
Order:
CONDITION
Enter condition:
Start:
NOW
Stop:
T+60
CONDITION :
Accept Order
Quit

## 2. Transfer & Initiate Comfort Care Order Set

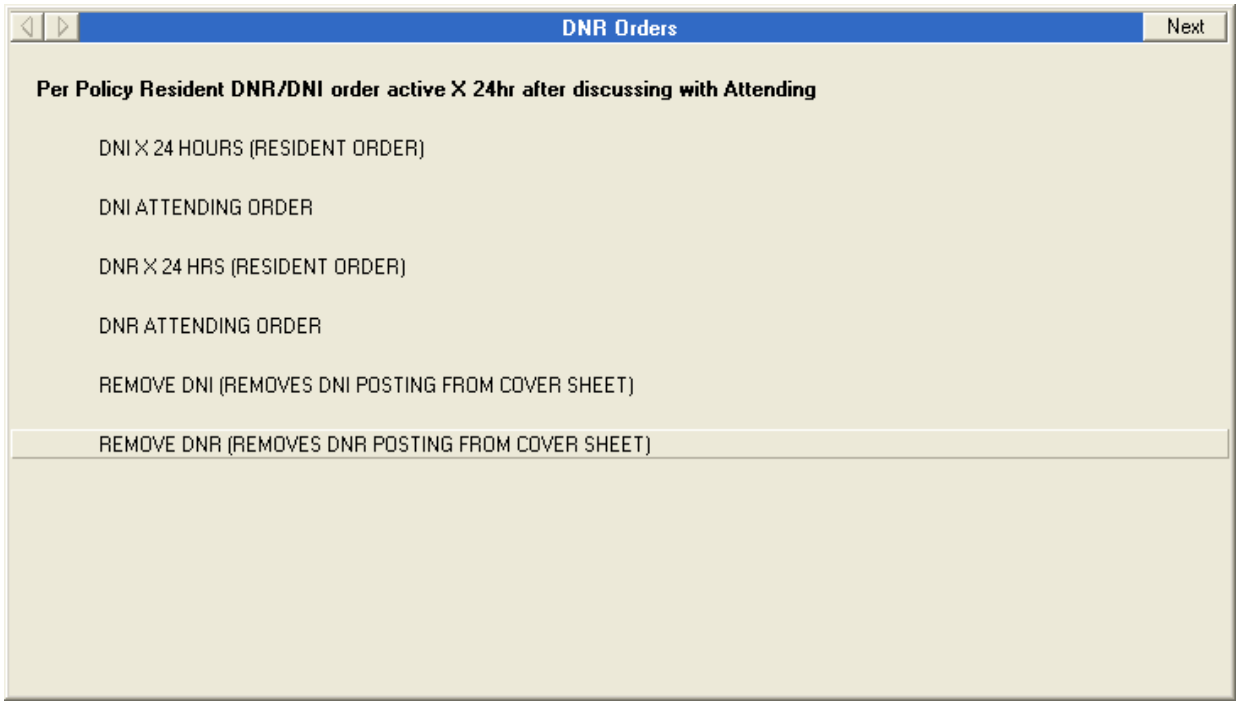





The remainder of the transfer order set is the same as the admission order set…….

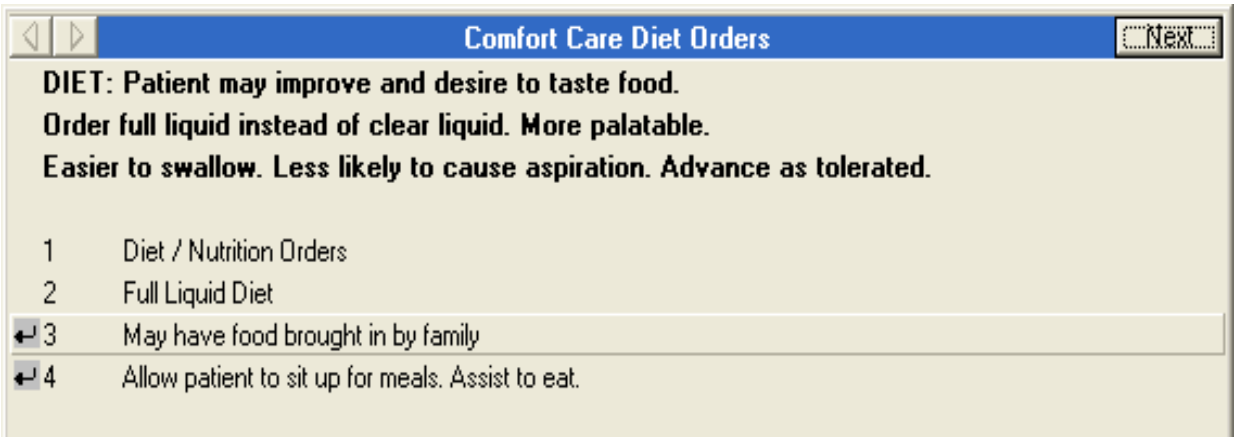
## 3. DNR/DNI Orders

Reminder to document and place orders that reflect the current Advance Care Plan and resuscitation preferences.



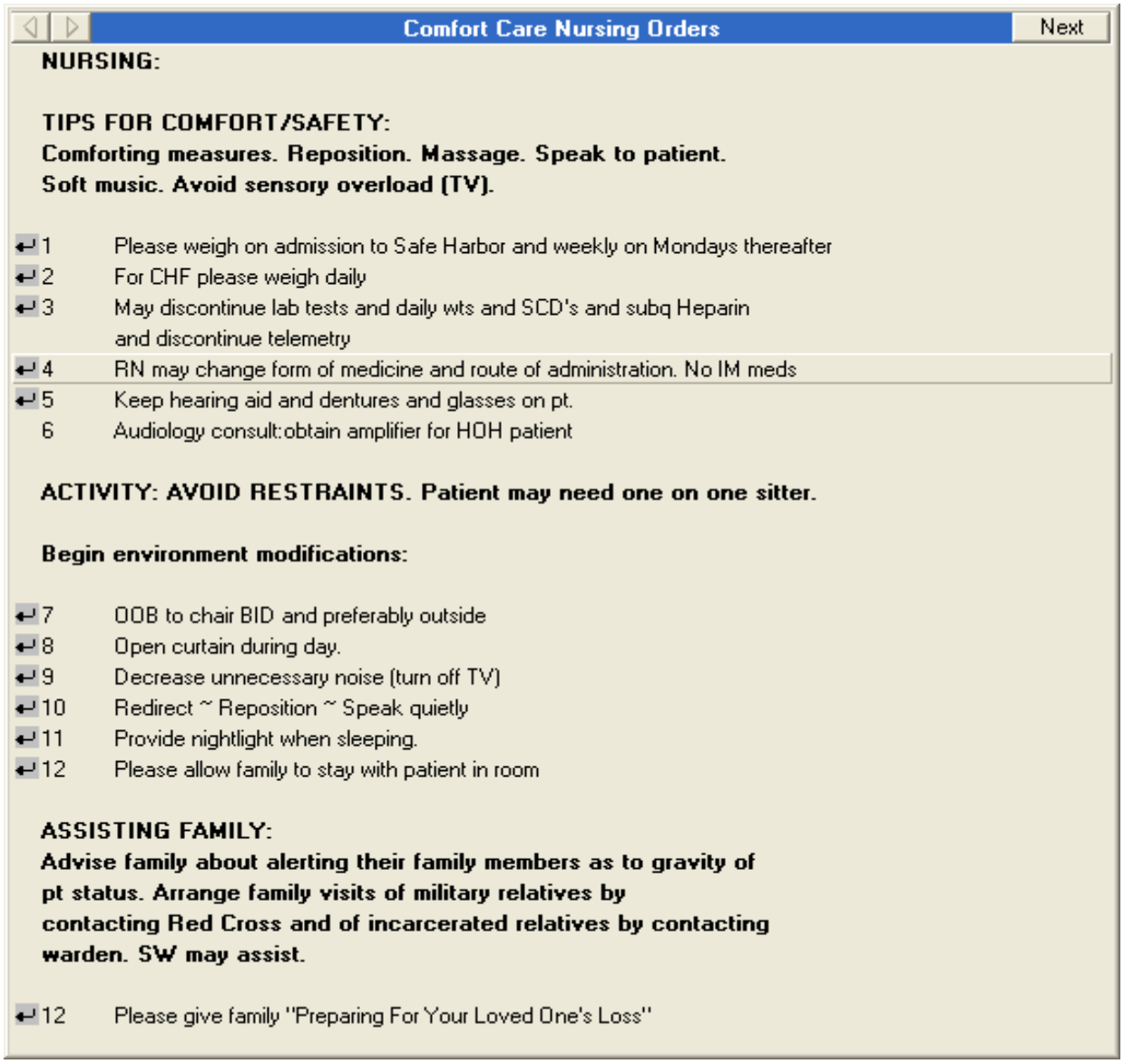
## 4. Diet Orders

Diet Orders: Default is full liquid diet but also include orders to encourage family to bring favorite foods for patient to participate in pleasure eating/feeding.



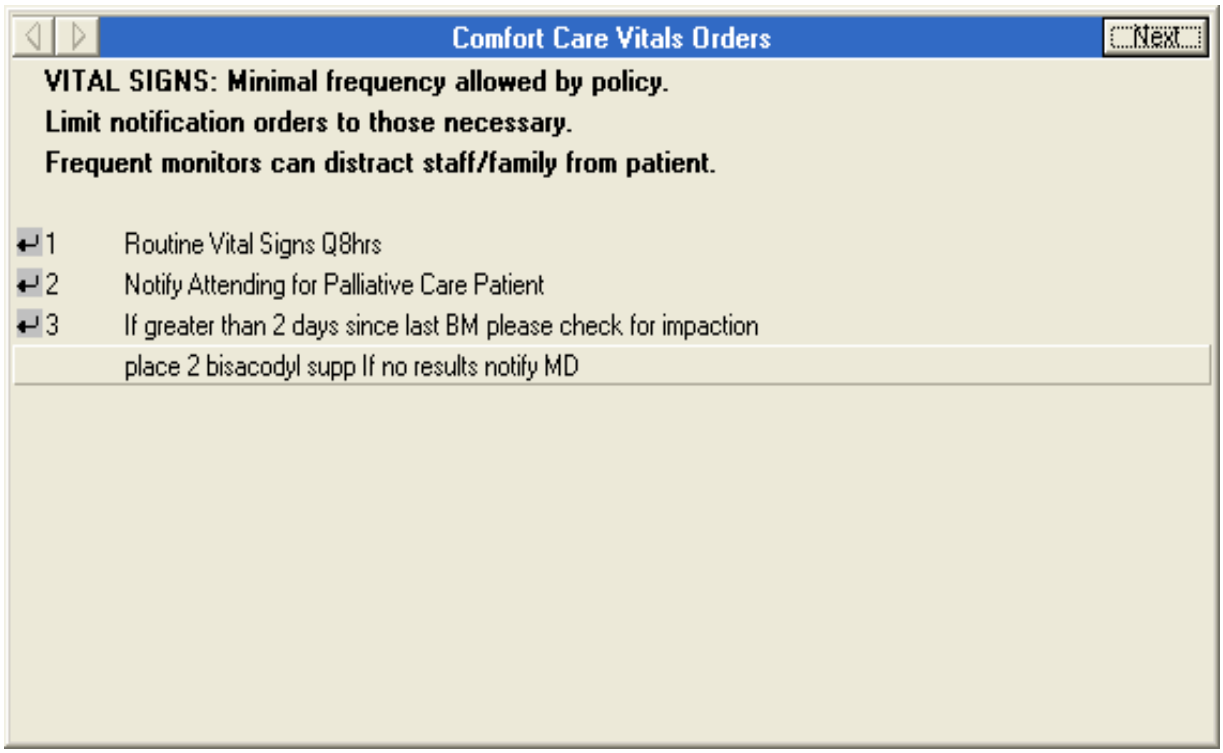
## 5. Nursing Orders

Activity Orders: Orders for environmental modifications to reduce or prevent delirium and that encourage patient, family and staff to encourage activity and positioning that maximizes patient comfort, safety and choice.



## 6. Vital Signs

Vital Sign Orders: Allow for customization of vital sign monitoring that de-emphasizes frequency and refocuses on symptom assessment, comfort ,and effectiveness of interventions. The call back parameters are based on control of symptom assessment instead of specific numbers.



## 7. Activity Orders

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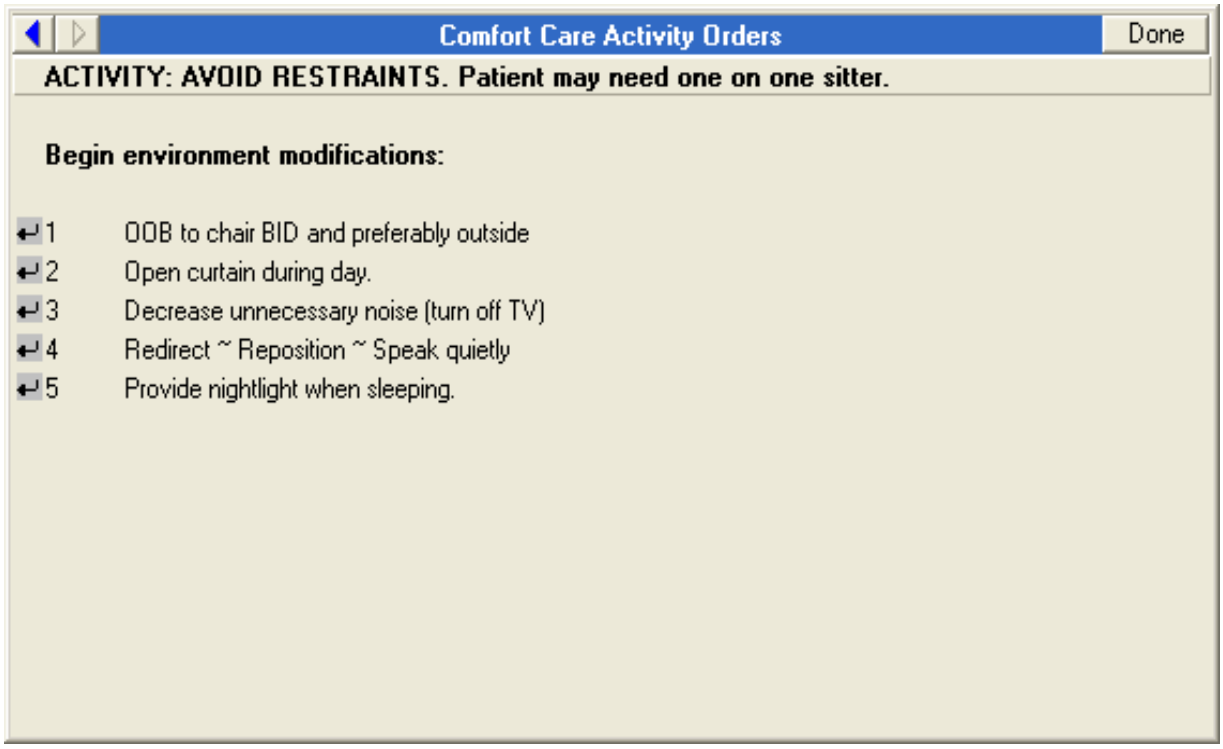
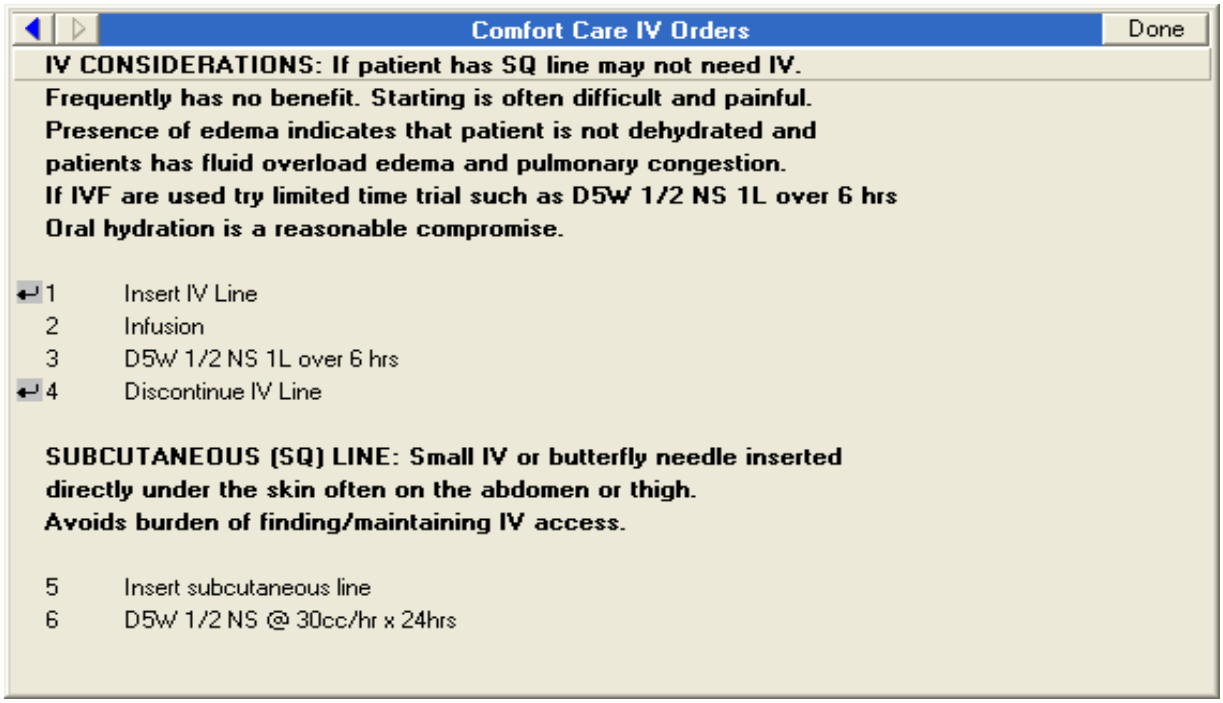


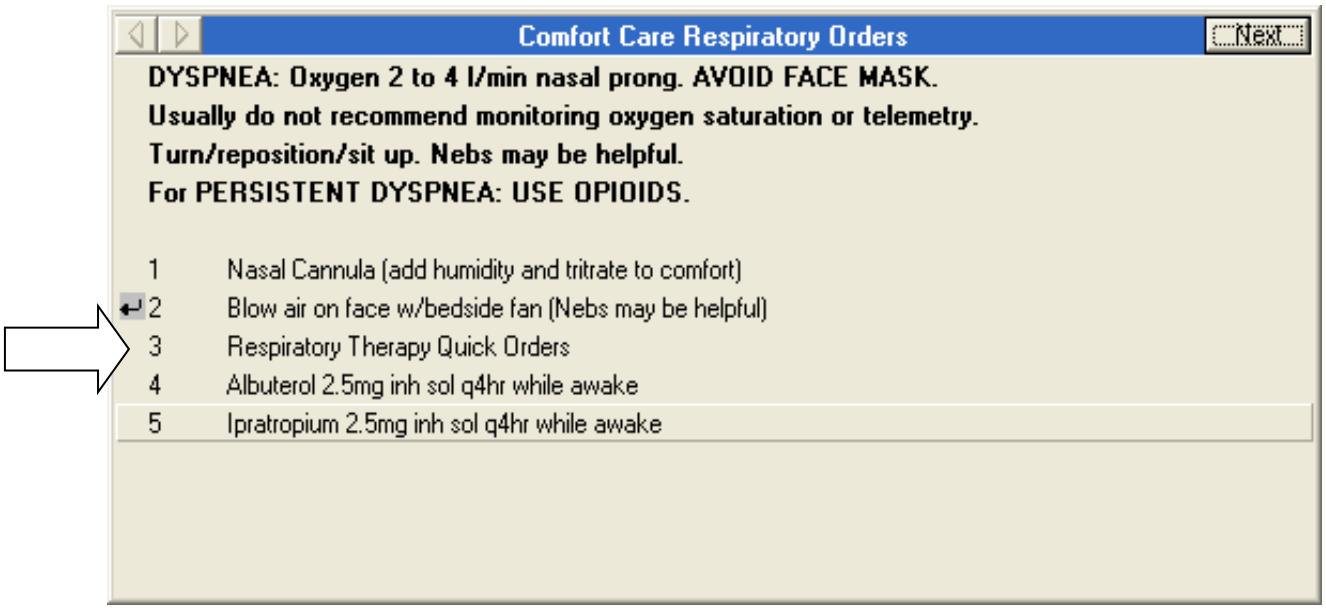
## 8. IV considerations

IV and Subcutaneous therapy: Parenteral hydration may play a role in patient comfort at Life's End; however, volume overload is a common iatrogenic problem in inpatient setting an end-of-life. In addition, maintaining an IV site is often painful, increases risk of infection and use of restraints. The use of subcutaneous line for parenteral access for medications and in some clinical situation fluids is a low burden option for parenteral access in almost all patients.



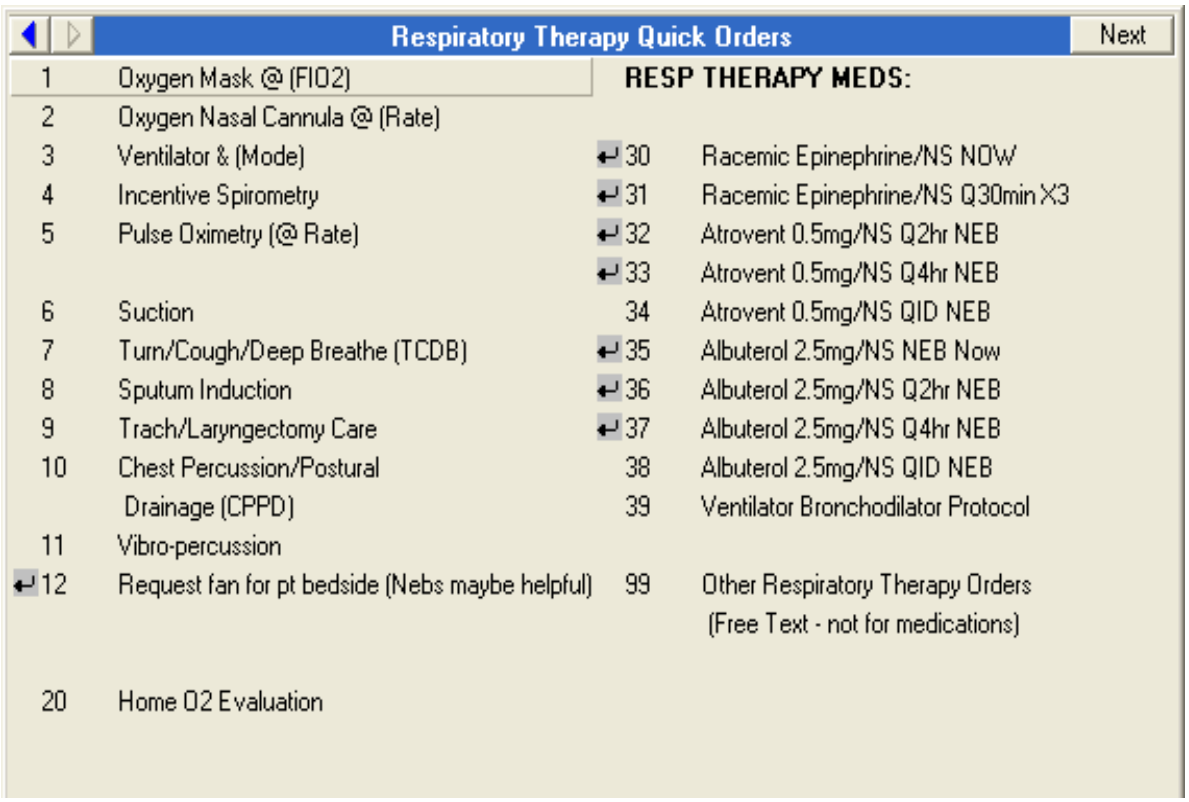
## 9. Respiratory Orders

Oxygen therapy is a potent symbol of medical care. Face masks are often uncomfortable and make patients feel more claustrophobic and dyspnic. These orders focus on the comfort of the patient as primary and correction of hypoxia as secondary. For most patients at end-of-life correction of hypoxia will not be a feasible goal but symptom control will.



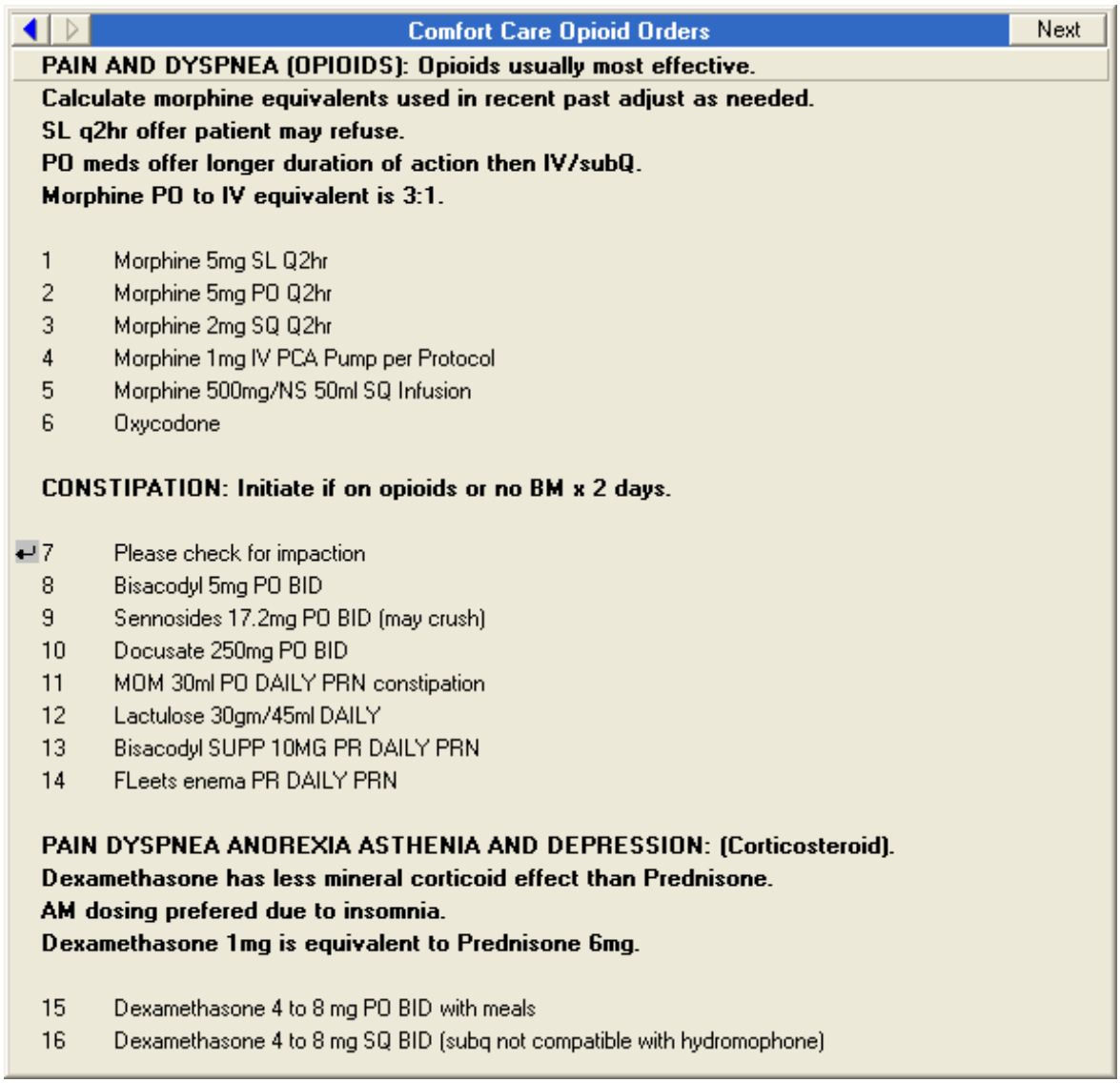
- **Components Submenu(s)**

This is an example of a component submenu, in this case it is for the standard quick orders for respiratory therapy but it can be a submenu to any quick order set the particular VAMC has constructed .



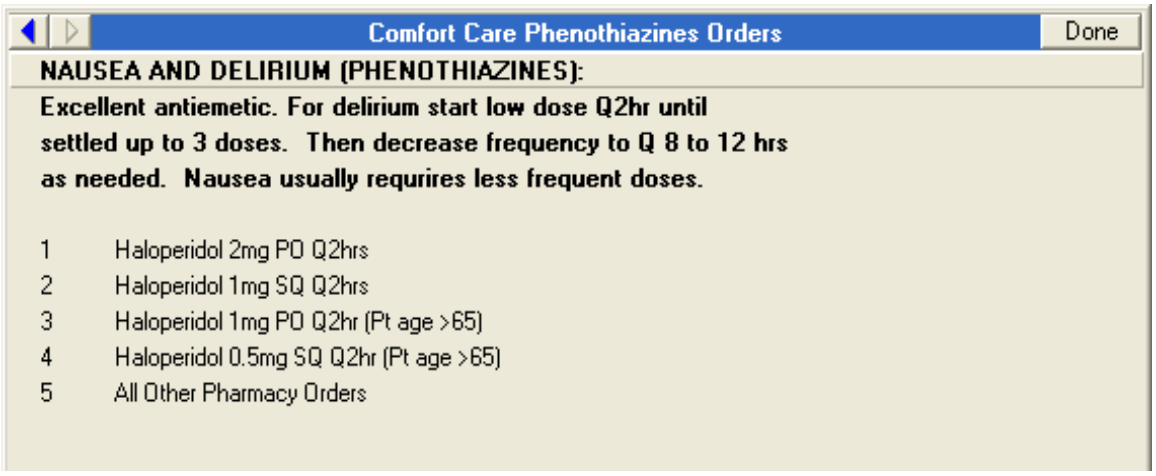
## 10. Pain & Dyspnea (Opioids)

Opioids are a key medication for pain and dyspnea. These medications are frequently underutilized in the inpatient setting at end-of-life. These orders are designed to encourage frequent assessment and uses a scheduled offer may refuse approach to increase the ability of patients to request and receive treatment and increase provider comfort with ordering and administering pain medication.



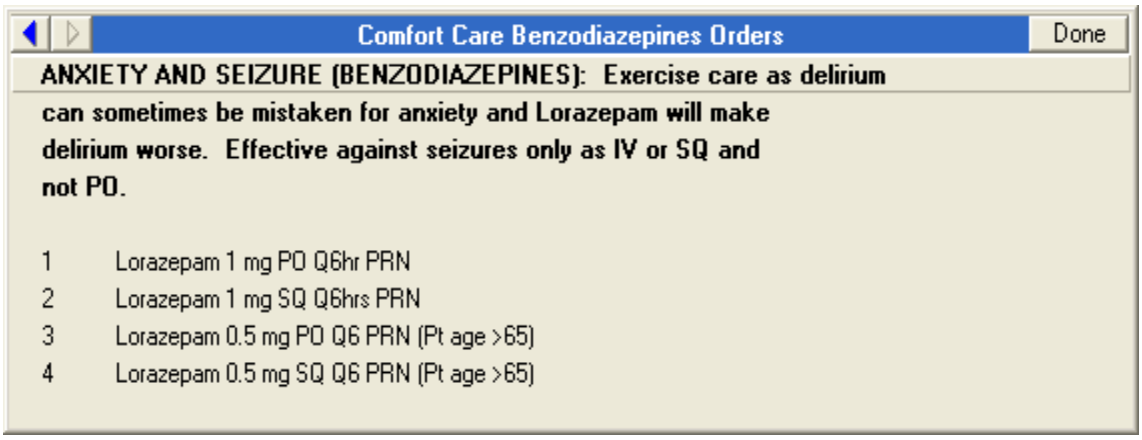
## 11. Nausea & Delirium (Phenothiazines)

Haloperidol is the mainstay of treatment for delirium at end-of-life. Haloperidol is an effective anti-emetic and by using one medication for more than one symptom helps simplifies symptom management at end-of-life.



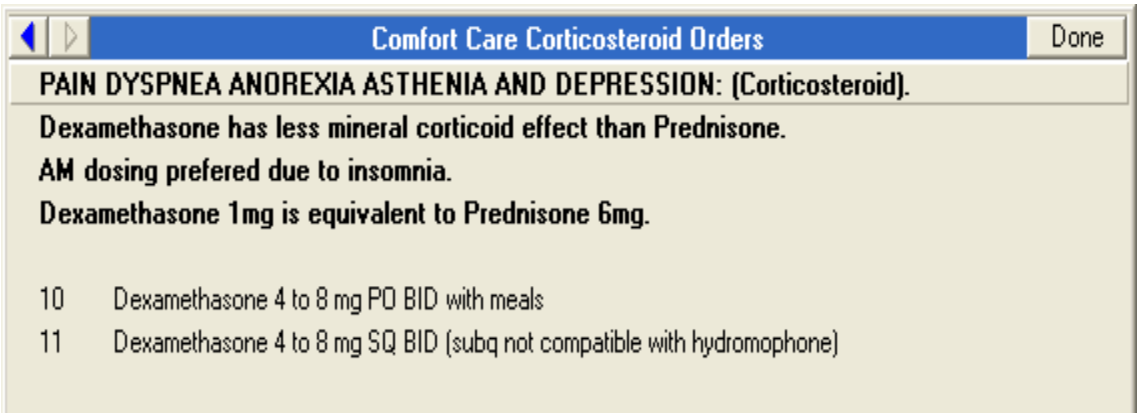

## 12. Anxiety & Seizures (Benzodiazepines)

Lorazepam is an effective medication for anxiety and when given parenterally is an effective anti-convulsant. Warnings regarding the potential of lorazepam to complicate treatment for delirium are imbedded in each order.



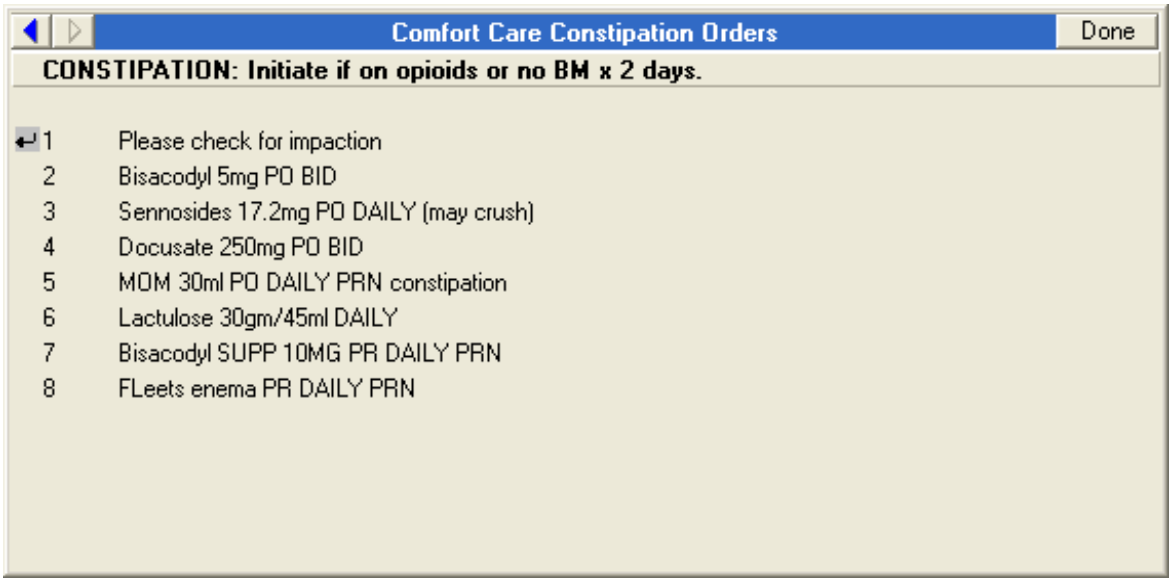
## 13. Pain Dyspnea, Anorexia, Asthenia & Depression: (Corticosteroid)

Dexamethasone is an effective adjuvant for many patients and the orders are set up to help providers quickly order medication. It is easier to convert from oral to parenteral routes when the same medication and dosages are used with both routes.



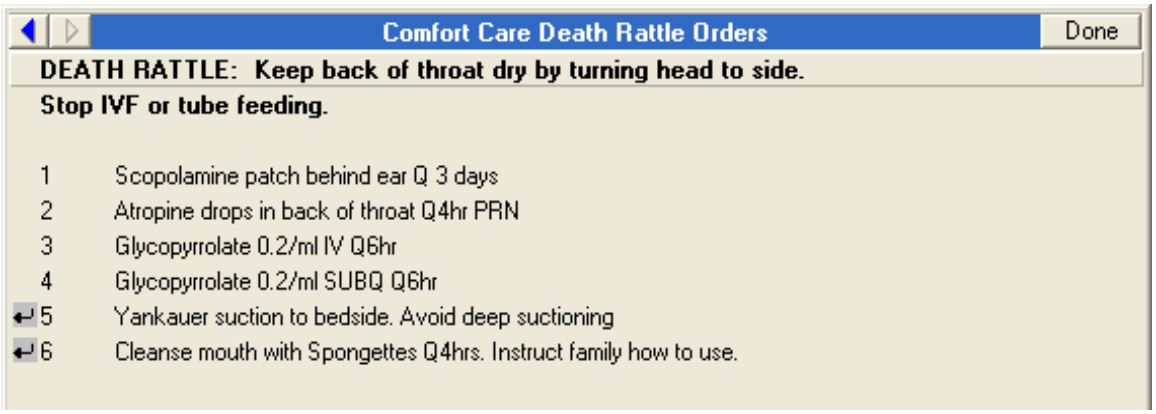

## 14. Constipation

Constipation is a very common symptom. The constipation orders also occur earlier under the opioid orders to encourage ordering a bowel regiment at the time the pain medication is ordered. It also occurs here so that it can be quickly identified if modification in the laxative therapy plan is needed.



## 15. Death Rattle Orders

Loud congested and moist sounding respirations are a common symptom and are particularly distressing to the family and staff.

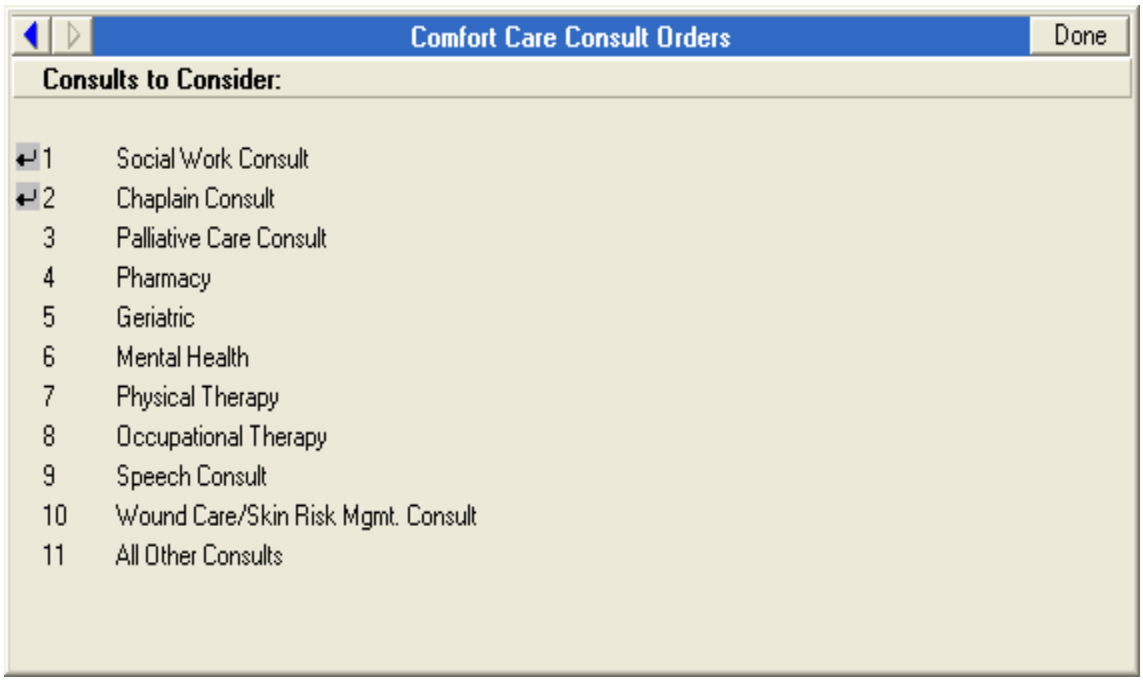


# 16. Additional Comfort Medications

Some patients may not need any of these adjuvant medications for specific problems while others would benefit from several of the options.

## 17. Consults

Encourage participation of the core members of the PCCT as well as specialty services of the specific VAMC.



F. Education Plan

It will be important to have an education plan for staff to successfully use, integrate and obtain buy-in from all of the clinical staff when implementing the CCOS.

There are two specific groups that will need tailored education and training.

1. Clinicians who will be using the order set to place orders in CPRS

   The clinicians need to understand where the order set is on their CPRS screen, how to pull up the order set and manipulate the CCOS to quickly place orders for patients. There may be a small core of clinicians who will use the order set routinely. These clinicians may be members of the PCCT or work on a specific hospice or palliative care unit. They frequently can become educators.

   Some clinicians may use the CCOS infrequently and/or with the assistance and guidance of the PCCT. A physician working in the Emergency Unit or a hospitalist on an impatient ward service or other location may need to use the CCOS to quickly start symptom management before the PCCT can provide a comprehensive evaluation with assessment and recommendations. If your VAMC has physician in training(medical students or residents), these individuals may rotate into the VAMC every month and including introduction to the CCOS as part of the orientation will be needed to maintain consistency in provider knowledge of the CCOS.

2. Nursing staff, respiratory therapy, dietary, pharmacist and any other individuals who routinely are part of the care team for patients in whom a CCOS may be used.

   Since the CCOS affects all aspects of the care provided to patients at end-of-life it is important that all staff have some understanding of the program and how it may affect their particular aspect of patient care. Examples include nursing staff using SQ lines, medications and the "offer may refuse" opioid order when they are used to providing only IV or PO medications. Or, a pharmacist may be unfamiliar with the use of sublingual morphine concentrate because it has not been used in the facility before. Dietary may not understand why a patient with a history of diabetes is now being allowed to have ice cream, or respiratory needs to understand that for some patients it may be more comfortable to use nasal cannula instead of a face mask when the goal is comfort.

   At the other VAMC that the CCOS has been implemented, widespread staff education has been provided. This is usually a brief, 30 minute overview, of the CCOS process to help everyone understand how the concept works, how orders may be different from the routine and stresses the need for integration of the CCOS into the institutional memory for the facility.