Hospice Inpatient (1691)

Version: 15 **Gen:** 11/3/2026

Location: _____

General

Admission

☐ **Admit to inpatient hospice** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:
Process Instructions:
Patient to remain under primary care of pre-hospice attending.

☐ **Code Status** (Required)
@CERMSGREFRESHOPT(674511:21703,,,1)@

☑ **Code Status**
DNR and Modified Code orders should be placed by the responsible physician.

○ **Full code** **Frequency:** Continuous **Priority:** Routine
Question(s):
Code Status decision reached by:

○ **DNR (Do Not Resuscitate)** (Required)

☑ **DNR (Do Not Resuscitate)** **Frequency:** Continuous **Priority:** Routine
Question(s):
Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

☐ **Consult to Palliative Care Service**

☑ **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine
Question(s):
Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?
Process Instructions:
Note: Please call Palliative care office 832-522-8391. Due to current resource constraints, consultation orders received after 2:00 pm M-F will be seen the following business day. Consults placed over weekend will be seen on Monday.

☐ **Consult to Social Work** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

○ **Modified Code** **Frequency:** Continuous **Priority:** Routine
Question(s):
Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
Modified Code restrictions:
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **Priority:** Routine
Question(s):
I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided.:
Treatment Restriction decision reached by:
Specify Treatment Restrictions:
Code Status decision reached by:
Process Instructions:
Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.

The Code Status and Treatment Restrictions are two SEPARATE sets of physician's orders. For further guidance, please click on the link below: Guidance for Code Status & Treatment Restrictions

Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.

If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

Isolation (Required)

Airborne plus Contact isolation is recommended for all Confirmed or Suspect COVID-19 patients regardless of aerosol generating procedure requirements in response to the OSHA standard published June 2021.

Please refer to the Confirmed COVID or PUI section in the **Clinical Resource Guide** for PPE guidance.

☐ **Airborne isolation status**

☑ **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics.** **Frequency:** Once **Priority:** Routine

☑ **Contact isolation status** **Frequency:** Continuous **Priority:** Routine **Comments:** Include eye protection

☐ **Patient may not require isolation. Will consult infection control.** **Frequency:** Until discontinued **Priority:** Routine

Isolation

☐ **Enteric isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Airborne isolation status**

☑ **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics.** **Frequency:** Once **Priority:** Routine

☐ **Contact isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Droplet isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Patient may not require isolation. Will consult infection control.** **Frequency:** Until discontinued **Priority:** Routine

Precautions

☐ **Aspiration precautions** **Frequency:** Continuous **Priority:** Routine

☐ **Fall precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Latex precautions** **Frequency:** Continuous **Priority:** Routine

☐ **Seizure precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

Nursing

Vital Signs

☐ **Vital signs - T/P/R/BP** **Frequency:** As needed **Priority:** Routine **Comments:** Vital signs as needed per patient/family request or comfort assessment

Activity

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Activity as tolerated** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Provide assistance when needed
Question(s):
Specify: ○ Activity as tolerated

Comfort Care

☐ **Maintain IV access** **Frequency:** Until discontinued **Priority:** Routine **Comments:** If IV access lost, please contact hospice agency or palliative care team for sublingual/subcutaneous medication orders. Do not attempt re-insertion of peripheral IV

☐ **sodium chloride 0.9% flush** **Dose:** 10 mL **Frequency:** PRN **PRN Reasons:** line care
Question(s):
Indication(s) for Once Reason:

☐ **Okay to discontinue Foley catheter for comfort** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine

☐ **Insert and maintain Foley**

☑ **Insert Foley catheter** **Frequency:** Once **Priority:** Routine
Question(s):
Type:
Size:
Urinometer needed:
Indication:
Primary Ordering Comments:
Foley catheter may be removed per nursing protocol.

☑ **Foley Catheter Care** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Orders: Maintain

☐ **Assist patient with personal hygiene** **Frequency:** As needed **Priority:** Routine

☐ **Oral care**

☐ **Oral care** **Frequency:** Every 4 hours **Priority:** Routine **Comments:** for comfort

☐ **Reposition for excessive secretions** **Frequency:** Until discontinued **Priority:** Routine

☐ **Gentle oral suction if needed** **Frequency:** As needed **Priority:** Routine

☐ **Suctioning: Nasotracheal** **Frequency:** As needed **Priority:** Routine **Comments:** Family may refuse
Question(s):
Route: ○ Nasotracheal

☐ **Suctioning: Oropharyngeal** **Frequency:** As needed **Priority:** Routine **Comments:** Family may refuse
Question(s):
Route: ○ Pharynx

☐ **Assess for signs/symptoms of discomfort** **Frequency:** Once **Priority:** Routine **Comments:** May include facial grimacing, furrowed brow, groaning, vocalization, muscle tension, clenched fists/teeth, withdrawal from touch, tremor, diaphoresis, flushing, tearing, restlessness, use of accessory respiratory muscles, nasal flaring, sustained tachypnea rate > 30 breaths/minute.
Question(s):
Assess:

☐ **Nursing wound care** **Frequency:** Every 12 hours **Priority:** Routine **Comments:** 1. Apply foam dressing (e.g. Mepilex) over bony prominences (e.g. sacrum, heels, elbows) to improve comfort and decrease risk of pressure ulcers due to patient immobility
Question(s):
Location: ○ Bilateral
Site: ○ Other
Specify: Bony prominences
Dressing Type: ○ Foam
Irrigate wound?
Apply:
Process Instructions:
This Nursing Order is NOT for a CONSULT for PT Wound Care or WOC nurse. The order is not transmitted to any department.

Do NOT use this order to request :
Bedside debridement, Ultrasound Therapy, Pulsed Lavage, Negative Pressure Vacuum Therapy, Compression therapy, WOC ongoing wound /ostomy management and teaching.

☐ **Turn patient** **Frequency:** Now then every 2 hours **Priority:** Routine **Comments:** As tolerated

Discontinue Interventions

☐ **Discontinue tube feeding** **Frequency:** Once **Priority:** Routine

Sign:_____ **Printed Name:**_____
Date/Time:_____

- ☐ **Discontinue feeding tube** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue nasogastric tube** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue esophageal temperature monitor** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue pulse oximetry** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue vital signs** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue telemetry** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Implantable defibrillator off** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue invasive hemodynamic monitoring** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue dialysis/CRRT** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue lab draws** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue bedside glucose checks** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue BIPAP** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue all radiologic imaging** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue restraints** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Discontinue SCD's** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine

Diet

- ○ **NPO** **Frequency:** Diet effective now **Priority:** Routine

Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

- ○ **Diet- Regular** **Frequency:** Diet effective now **Priority:** Routine

Question(s):
Diet(s): ○ Regular
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

Notify Physician

- ☐ **Notify Attending and Treatment Team that patient is now under Hospice Care** **Frequency:** Until discontinued **Priority:** Routine
- ☐ **Notify hospice when inpatient encounter is transitioned to hospice encounter to obtain additional admission orders** **Frequency:** Until discontinued **Priority:** Routine
- ☐ **Call LifeGift at time of admission to Hospice if not previously completed** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Do not speak with family regarding organ/tissue donation at this time.
- ☐ **At time of death, call hospice agency, attending physician and LifeGift** **Frequency:** Until discontinued **Priority:** Routine
- ☐ **Bedside RN to coordinate with hospice agency if applicable and complete Funeral Home information on Deceased Navigator** **Frequency:** Until discontinued **Priority:** Routine

Registered Nurse (RN) Pronouncement

- ☐ **Registered Nurse (RN) pronouncement** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Comments:** Only registered nurses currently licensed in the State of Texas and employed by Houston Methodist Willowbrook Hospital functioning as a validated Registered Nurse (RN) with documented competency may pronounce death in patients in whom death is anticipated. Refer to POLICY # NU006_HMW.

Registered Nurse (RN) Pronouncement

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Registered Nurse (RN) pronouncement** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Only registered nurses currently licensed in the State of Texas and employed by Houston Methodist Cypress Hospital functioning as a validated Registered Nurse (RN) with documented competency may pronounce death in patients in whom death is anticipated. Refer to POLICY PCPS118 System BE003 Determination of Death.

IV Fluids

Medications

Scheduled Medications

○ **dexamethasone (DECADRON) tablet** **Dose:** 4 mg **Route:** oral **Frequency:** daily

○ **dexamethasone (DECADRON) injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** daily
Question(s):
Indication(s) for Once Reason:
Select if injection being given for oral use:

PRN Medications

Dry Eyes

☐ **dextran 70-hypromellose (ARTIFICIAL TEARS) ophthalmic solution** **Dose:** 2 drop **Frequency:** every 4 hours PRN **PRN Reasons:** dry eyes
Product Admin Instructions:
For Ophthalmic use only

Dry Mouth

☐ **saliva stimulant (BIOTENE) spray** **Frequency:** PRN **PRN Reasons:** dry mouth

PRN Fever

☐ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** for fever GREATER than 100.8 F **PRN Reasons:** fever
Question(s):
Allowance for Patient Preference:
Indication(s) for Once Reason:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **acetaminophen (TYLENOL) suppository** **Dose:** 650 mg **Route:** rectal **Frequency:** every 4 hours PRN **PRN Comment:** for fever GREATER than 100.8 F **PRN Reasons:** fever
Admin Instructions:
Use suppository if patient can not take oral medications.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

Excessive Secretions

☐ **atropine 1 % for Sublingual Use** **Dose:** 1 drop **Route:** sublingual **Frequency:** every 2 hour PRN **PRN Reasons:** excessive secretions
Admin Instructions:
** FOR SUBLINGUAL USE ONLY **

☐ **glycopyrrolate (ROBINUL) injection** **Dose:** 0.4 mg **Route:** intravenous **Frequency:** every 2 hour PRN **PRN Reasons:** excessive secretions
Admin Instructions:
Administer 200 microgram IV of glycopyrrolate for every 1 mg of neostigmine. Doses of IV glycopyrrolate should rarely exceed 1 mg or 1,000 micrograms

☐ **scopolamine (TRANSDERM-SCOP) 1.5 mg patch** **Dose:** 1 patch **Route:** transdermal **Frequency:** every 72 hours PRN **PRN Comment:** excessive secretions

Delirium/Restlessness

☐ **haloperidol (HALDOL) oral solution** **Dose:** 2 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** agitation
Question(s):
Indication:
Product Admin Instructions:
May cause QTc prolongation.

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **haloperidol lactate (HALDOL) injection** **Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** delirium
Question(s):
Indication:
Indication(s) for Once Reason:
Product Admin Instructions:
May cause QTc prolongation.

☐ **chlorproMAZINE (THORAZINE) injection** **Dose:** 25 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication:
Admin Instructions:
For delirium.
Product Admin Instructions:
May cause QTc prolongation.

Pain/Dyspnea

If patient on opioid or sedation infusion, please review to ensure adequate dosing for comfort medications.

☐ **albuterol (PROVENTIL) nebulizer solution** **Dose:** 2.5 mg **Route:** nebulization **Frequency:** every 15 min PRN **PRN Reasons:** shortness of breath
Question(s):
Aerosol Delivery Device:

☐ **morPHINE subcutaneous q1h prn** **Route:** subcutaneous **Frequency:** every 1 hour prn **PRN Reasons:** shortness of breath
Question(s):
Indication(s) for Once Reason:

☐ **morPHINE IV 2 mg q1h prn** **Dose:** 2 mg **Route:** intravenous **Frequency:** every 1 hour prn **PRN Reasons:** moderate pain (score 4-6)
severe pain (score 7-10)
shortness of breath
Question(s):
Indication(s) for Once Reason:

☐ **morphine oral solution q1h prn** **Dose:** 5 mg **Route:** oral **Frequency:** every 1 hour prn **PRN Reasons:** shortness of breath
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient cannot receive oral tablet medication but can receive oral solution.

☐ **HYDROmorphone (DILAUDID) subcutaneous** **Route:** subcutaneous **Frequency:** every 1 hour prn **PRN Reasons:** shortness of breath

☐ **HYDROmorphone (DILAUDID) IV q1h prn** **Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 1 hour prn **PRN Reasons:** moderate pain (score 4-6)
severe pain (score 7-10)

☐ **HYDROmorphone (DILAUDID) oral solution** **Dose:** 1 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** shortness of breath
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient cannot receive oral tablet medication but can receive oral solution.

Anxiety

○ **diazePAM (VALIUM) tablet** **Dose:** 5 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** anxiety, myoclonus
Question(s):
Indication(s):

○ **diazePAM (VALIUM) injection** **Dose:** 5 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Comment:** myoclonus **PRN Reasons:** anxiety
Question(s):
Indication:

Sign:_____ **Printed Name:**_____
Date/Time:_____

○ **haloperidol lactate (HALDOL) injection** **Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** delirium
Question(s):
Indication:
Indication(s) for Once Reason:
Product Admin Instructions:
May cause QTc prolongation.

○ **LORazepam (ATIVAN) tablet** **Dose:** 1 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** anxiety
Question(s):
Indication(s): ○ Anxiety

○ **LORazepam (ATIVAN) injection** **Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** anxiety
Question(s):
Indication(s): ○ Anxiety
Indication(s) for Once Reason:

Myoclonus

○ **diazePAM (VALIUM) tablet** **Dose:** 5 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** myoclonus
Question(s):
Indication(s):

○ **diazePAM (VALIUM) injection** **Dose:** 5 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Comment:** myoclonus
Question(s):
Indication:

○ **LORAZepam (ATIVAN) tablet 1 mg** **Dose:** 1 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** myclonus
Question(s):
Indication(s):

○ **LORazepam (ATIVAN) injection** **Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** myoclonus
Question(s):
Indication(s): ○ Myoclonus
Indication(s) for Once Reason:

Insomnia

☐ **ramelteon (ROZEREM) tablet** **Dose:** 8 mg **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep

☐ **doxepin (SINEquan) 10 mg/mL solution - oral** **Dose:** 10 **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep
Question(s):
Indication:
Indication:
Admin Instructions:
May cause QTc prolongation.

☐ **doxepin (SINEquan) 10 mg/mL solution - sublingual** **Dose:** 10 **Route:** sublingual **Frequency:** nightly PRN **PRN Reasons:** sleep
Question(s):
Indication:
Indication:
Admin Instructions:
May cause QTc prolongation.

Itching

☐ **cetirizine (ZyrTEC) tablet** **Dose:** 10 mg **Route:** oral **Frequency:** daily PRN **PRN Comment:** for itching in patients >65 years of age

☐ **diphenhydrAMINE (BENADRYL) injection** **Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** itching
Question(s):
Indication(s) for Once Reason:

Constipation

☐ **bisacodyl (DULCOLAX) suppository** **Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **PRN Reasons:** constipation

☐ **senna (SENOKOT) tablet** **Dose:** 2 tablet **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** constipation

Anti-emetics

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Product Admin Instructions:
May cause QTc prolongation.

☐ **ondansetron (ZOFRAN) tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Product Admin Instructions:
May cause QTc prolongation.

☐ **ondansetron (ZOFRAN) IV Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Product Admin Instructions:
May cause QTc prolongation.

☐ **prochlorperazine (COMPAZINE) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting

☐ **metoclopramide (REGLAN) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting

Labs

Cardiology

Imaging

Other Studies

Respiratory

Premedication prior to extubation

☐ **morPHINE injection 2 mg Dose:** 2 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s) for Once Reason:

☐ **morPHINE injection 4 mg Dose:** 4 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s) for Once Reason:

☐ **hydromorPHONE (DILAUDID) injection 1 mg Dose:** 1 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences

☐ **LORAZepam (ATIVAN) injection 1 mg Dose:** 1 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s):
Indication(s) for Once Reason:

☐ **glycopyrrolate (ROBINUL) injection 0.4 mg Dose:** 0.4 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Administer 200 microgram IV of glycopyrrolate for every 1 mg of neostigmine. Doses of IV glycopyrrolate should rarely exceed 1 mg or 1,000 micrograms

Respiratory

☐ **OK to extubate**

☑ **Ensure neuromuscular blockers discontinued and test train of four adequate for extubation Frequency:** Until discontinued **Priority:** Routine

☑ **Prepare for terminal extubation of a mechanically ventilated patient Frequency:** Until discontinued **Priority:** Routine

☑ **Prior to terminal extubation, ensure patient/family informed, agree to continue DNR/DNI, OOH if discharged. Frequency:** Until discontinued **Priority:** Routine

☑ **Oxygen support/humidification post-extubation as needed for comfort via BiPaP, NRB, NC, simple face mask Frequency:** Until discontinued **Priority:** Routine

☑ **Perform terminal extubation during Time Out, to include but not limited to the registered nurse (RN), respiratory care practitioner (RCP), and the Charge Nurse (CN, if available). Frequency:** Until discontinued **Priority:** Routine

☑ **Extubate Frequency:** Once **Priority:** Routine

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Oxygen therapy - Nasal cannula** **Frequency:** Continuous **Priority:** Routine
Question(s):
Initial Device: ○ Nasal Cannula
Device:
SpO2 Goal: 93% - 98%
SpO2 Goal: 93% - 96%
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

☐ **Oxygen therapy - Non - rebreather mask** **Frequency:** Continuous **Priority:** Routine
Question(s):
Initial Device: ○ Non-rebreather mask
Device:
SpO2 Goal: 93% - 98%
SpO2 Goal: 93% - 96%
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

☐ **Oxygen therapy - Simple face mask** **Frequency:** Continuous **Priority:** Routine
Question(s):
Initial Device: ○ Simple Face Mask
Device:
SpO2 Goal: 93% - 98%
SpO2 Goal: 93% - 96%
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

☐ **Wean down oxygen for signs of dyspnea, comfort, family request** **Frequency:** Until discontinued **Priority:** Routine

☐ **BIPAP** **Frequency:** Once **Priority:** Routine **Comments:** for comfort per RT
Question(s):
Instructions for As Directed:
Mode:

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

☐ **Consult to Case Management** **Frequency:** Once **Priority:** Routine
Question(s):
Consult Reason: ○ Other specify
Specify: Disposition planning/support needs
Reason for Consult?
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

☐ **Consult to Palliative Care Service**

Sign:_____ **Printed Name:**_____
Date/Time:_____

- [x] **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine
  Question(s):
  Priority:
  Reason for Consult?
  Order?
  Name of referring provider:
  Enter call back number:
  Reason for Consult?
  Process Instructions:
  Note: Please call Palliative care office 832-522-8391. Due to current resource constraints, consultation orders received after 2:00 pm M-F will be seen the following business day. Consults placed over weekend will be seen on Monday.

- [ ] **Consult to Social Work** **Frequency:** Once **Priority:** Routine
  Question(s):
  Reason for Consult:
  Reason for Consult?

Additional Orders

Additional Hospice Orders

- [ ] **Order comfort cart** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Provide bereavement packet (grief support)** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Assist with pet visitation if requested** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Contact PAWS @713-305-4887 for any needs
- [ ] **Houston Methodist Nurse Practitioner allowed to complete death pronouncement** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Notify security for any special needs family has regarding deceased** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Patient/Family to review/agree on medications, devices, infusions, and nutrition** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Review medication list with patient/ family explaining plan for continuation or discontinuation and role in comfort** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Assess preferences end of life practices, cultural/spiritual traditions, rituals, body preparation requests** **Frequency:** Until discontinued **Priority:** Routine
- [ ] **Provide patient/family education, information regarding signs/symptoms of death and dying** **Frequency:** Until discontinued **Priority:** Routine

Sign:_____ **Printed Name:**_____
Date/Time:_____