Palliative Care Approach to Expectant Care Toolkit

1. Expectant/Palliative Care Triage and Treatment Plan
2. HICS 254 Disaster Victim/Patient Tracking form and instructions
3. Expectant – Comfort Care Supply List
4. Comfort Care Physician Orders
5. Expectant-Comfort Care Medication List
6. Coroner’s case instructions
7. Coroner’s case form
8. HMNH Palliative Care Services – Handout at CHA conference
9. HMNH Bereavement Guide – handout at CHA conference
10. HMNH Grief Support Guide – handout at CHA conference
11. Anticipate, Plan, Deter Personal Resilience Plan – handout at CHA conference
Expectant/Palliative Care Triage and Treatment Plan

Expectant/Palliative Care Triage will be set up in the Inpatient Physical Therapy Gym. PT equipment will be rearranged to make room for cots and carts for triage.

Patients will be triaged and transported directly from external or other triage areas by transport to the Expectant/Palliative Care Triage area.

Nursing staff that has completed the End of Life Course and Anticipate, Plan and Deter for staff resilience will be the pool of staff assigned to the Expectant/Palliative Care Triage area.

Staffing for this area will include a Medical Surgical RN, a social worker and a chaplain.

The RN is responsible to keep the HICS 254 form for victim tracking current and ultimately submitted to Incident Command.

All staff assigned to Expectant/Palliative Care Triage are expected to use the PsySTART self monitoring form to monitor their resilience and need a change in assignment.

Supply carts have been stocked and will be brought to the Expectant/Palliative Care Triage area by staff assigned to the triage area.

I-connect is the primary source for communication. Alternate communication device is a 2-way radio kept charged in the ED Manager office.

All patients that come in to the hospital following a disaster, and die as a result of their injuries while in the hospital need to be treated as a Coroners Case. All bodies of the deceased need to have the following:

- All deaths are reported to Incident Command.
- Any and all personal belongings and identifying materials need to be kept with the patient at all times including clothes, phones, valuables and any identifying materials.
- If no family is available at the time of death, any clothing and identifying features (wallets/purses/phones) should be bagged and labeled and placed inside the body bag with the patient.
- All patients who die as a result of injury due to a disaster need to be phoned in to the Coroner’s Office and reported and a coroner’s case number obtained.
- A Form 18 must be completed on all these deaths.
- Follow the hospital protocol for coroners cases
- Coroner’s Office # to report a death: 1(323)343-0711
- The deceased will be placed in a body bag with accompanying identification and will be stored either in the morgue or the mass fatality area to wait pick up by the coroner.
HICS 254 - DISASTER VICTIM / PATIENT TRACKING

PURPOSE: The HICS 254 Disaster Victim / PatientTracking records the triage, treatment, and disposition of victims/patients of the event seeking medical attention.

ORIGINATION: Completed by the Patient Tracking Manager or team members.

COPIES TO: Distributed to the Situation Unit Leader, with copies to Patient Registration Unit Leader, Planning Section Patient Tracking Manager, Medical Care Branch Director, and the Documentation Unit Leader.

NOTES: The form is completed upon arrival of the first patient and updated periodically. Copies of the form are sent to the Planning Section Patient Tracking Manager each hour and at the end of each operational period until disposition of the last victim(s) are known. If additional pages are needed, use a blank HICS 254 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>TITLE</th>
<th>INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Incident Name</td>
<td>Enter the name assigned to the incident.</td>
</tr>
<tr>
<td>2</td>
<td>Operational Period</td>
<td>Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.</td>
</tr>
<tr>
<td>3</td>
<td>Area</td>
<td>Enter the triage or specific treatment area (e.g., Triage, Immediate Treatment Area).</td>
</tr>
<tr>
<td></td>
<td>Field Tag Number</td>
<td>Enter field triage tag number.</td>
</tr>
<tr>
<td></td>
<td>Medical Record Number</td>
<td>Enter hospital medical record number if available.</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Enter the full name of victim/patient.</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>Enter sex: M for male/F for female.</td>
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<tr>
<td></td>
<td>DOB / Age</td>
<td>Enter date of birth and age.</td>
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<tr>
<td></td>
<td>Triage Category</td>
<td>Enter the triage category assigned to patient.</td>
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<tr>
<td></td>
<td>Location / Time of Procedures</td>
<td>Enter location destination and time patient leaves triage or treatment area for a test or procedure.</td>
</tr>
<tr>
<td></td>
<td>Disposition / Time</td>
<td>Enter the letter of the disposition category and time of disposition.</td>
</tr>
<tr>
<td>4</td>
<td>Prepared by</td>
<td>Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.</td>
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### 1. Incident Name

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<thead>
<tr>
<th>FIELD TAG NUMBER</th>
<th>MEDICAL RECORD NUMBER</th>
<th>NAME (LAST NAME, FIRST NAME)</th>
<th>SEX (M/F)</th>
<th>DOB / AGE</th>
<th>TRIAGE CATEGORY</th>
<th>LOCATION / TIME OF PROCEDURES (CT, X-RAY, ETC.)</th>
<th>DISPOSITION / TIME (D) DISCHARGE</th>
<th>(A) ADMIT</th>
<th>(S) SURGERY</th>
<th>(T) TRANSFER</th>
<th>(M) MORGUE</th>
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<td>Immediate</td>
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<td>Minor</td>
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<td>Expired</td>
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### 2. Operational Period (#)

<table>
<thead>
<tr>
<th>DATE FROM</th>
<th>TO</th>
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<tbody>
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<table>
<thead>
<tr>
<th>TIME FROM</th>
<th>TO</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Area (Triage or Specific Treatment Area)

<table>
<thead>
<tr>
<th>PRINT NAME</th>
<th>SIGNATURE</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### 4. Prepared by

**Purpose:**
Records the triage, treatment, and location of victims/patients

**Originator:**
Patient Tracking Manager or team

**Copies to:**
Situation Unit Leader, Patient Registration Unit Leader, Planning Section Patient Tracking Manager, Medical Care Branch Director, and Documentation Unit Leader
Expectant-Comfort Care Supply List
(For Approx 40 Patients)

**Basic Linen Cart**
Blankets
Flat Sheets
Pillow Cases
Towels
Wash Cloths

**Paperwork**
Form 18
Comfort Care Order Sets
Palliative Care Brochure
Bereavment Packets
Greif Support Group Guide
Mortuary List

**Supply Cart**
S/M/L Gloves (4 boxes of each)
Body bags
Suction Canisters
(Supply Cart Continued)

Oral Care Kits x 40
Yankauer Suction Tip x 40
Yankauer Suction Tubing x 100
2 Inch Ace Wraps x 40
4 Inch Ace Wraps x 40
Curlex 2 inch x 30
Curlex 4 inch x 30
4 Inch Sterile Gauze Packs x 20
Non-Sterile Gauze x 40 Packs
3 cc Syringes x 4 Boxes
5 cc Syringes x 2 Boxes
10 cc Syringes x 1 Box
18 Gauge 1 inch Needles x 1 Box
22 Gauge 1 inch Needles x 1 Box
1 Inch paper Tape x 2 box
1 Inch Micropore tape x 4 boxes
IV, Primary- tubing x 80
IV, Secondary – Tubing x 80
Sharpies x 5
Cardboard Splints Large (Leg) x 20
Cardboard Splints Medium (Arm) x 20
Disposable Bed Pans x 40
Disposable Urinals x 40
Incontinence Briefs x 2 packages
Foley Catheter kits x 4
Temp a Dots
PPE equipment For Staff
   Isolation Gowns
   Isolation Masks
   S/M/L Non-sterile Gloves
Bath Basins x 40
Emesis basin x 20
Water Pitcher Sets x 40

**Equipment**

IV Poles – At Least 20
PCA Pumps x 3
PCA Key
Pixis Access
IV Pumps x 20
Suction Set Up
Clip Boards x 4
**Comfort Care Physician’s Orders**

**Medications**

**Constipation** (Select one drug only)
- Bisacodyl 10mg PR every other day if no BM for 72h
- Senna 8.6 mg PO/NG BID
- Other: ____________________________

**Nausea/Vomiting** (Select one drug only)
- Prochlorperazine 10 mg PO q6h prn N/V
- Prochlorperazine 25 mg PR q12h prn N/V
- Ondansetron 4 mg PO Q4h prn N/V
- Ondansetron 4 mg IV Q4h prn N/V
- Other: ____________________________

**Anxiety/Terminal Agitation**
- Lorazepam ____mg PO/NG q ____h prn anxiety
  (recommended dose 0.5-1mg)
- Lorazepam ____mg IV q ____h prn anxiety
  (recommended dose 0.5-1mg)
- Other: ____________________________

**Delirium**
- Haloperidol elixir ____mg PO q ____hrs prn delirium
  (0.5-1mg recommended dose)
- Haloperidol ____mg IM q ____hrs prn delirium
  (0.5-1mg recommended dose)

**Terminal Congestion**
- Scopolamine Patch 1.5mg q 72h PRN congestion
- Atropine 1% Ophth solution: 2 drops SL q6h prn unrelieved congestion
- Glycopyrrolate ____mg IV q ____h prn unrelieved congestion
  (acceptable dose 0.1-0.4mg/kg, 0.8mg max/day)

- If more than one drug is selected apply Scopolamine patch first. Use additional drug(s) for unrelieved congestion.

**Eye Drops**
- Artificial Tears 2 drops OU q2h

**Pronouncement**
- Notify MD when patient expires
- Okay for Registered Nurse to pronounce

**Transfer**
- Downgrade to med/surg
- Downgrade to med/surg if patient does not expire within 4 hours

**Other Orders**

**IV Fluids**
- Discontinue IV Fluids
- IV Fluids at 10ml/hr

**Diet**
- Ice Chips/Oral gratification
- NPO
- Other: ____________________________

**PRINT NAME:** ____________________________  **DATE/TIME:** ____________________________

**DOCTOR’S SIGNATURE:** ____________________________

**NURSE’S SIGNATURE:** ____________________________  **DATE/TIME NOTED:** ____________________________
Suggestions for End-of-Life Symptom Management (Adult)

Pain Management
The full effect of an increased continuous infusion will not be felt until a steady state is reached, until then, bolus doses are most effective in managing a patient’s pain.

Opiates
1. To initiate analgesia promptly start with a bolus (2-5mg Morphine IV x1).
2. Start Morphine drip: Recommended 2-5mg per hour.
3. Consider patient’s current opiate requirement.

Equianalgesic Opiate Conversion Table

<table>
<thead>
<tr>
<th>Name</th>
<th>Oral</th>
<th>IV</th>
<th>Duration</th>
<th>1/2 life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30-60mg</td>
<td>10mg</td>
<td>3-7 hours</td>
<td>1.5-2 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5mg</td>
<td>1.5mg</td>
<td>4-5 hours</td>
<td>2-3 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20mg</td>
<td>--</td>
<td>4-6 hours</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30mg</td>
<td>--</td>
<td>4-8 hours</td>
<td>3.3-4.5 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>20mg</td>
<td>--</td>
<td>4-6 hours</td>
<td>15-30 hours</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1.5-6</td>
</tr>
<tr>
<td>Codeine</td>
<td>200mg</td>
<td>120mg IM</td>
<td>4-6 hours</td>
<td>3 hours</td>
</tr>
</tbody>
</table>

***Switching from one opiate to another does not confer complete cross-tolerance: patient may require less of the new opiate

Pain Needs Careful Assessment
- Differentiate between anxiety, delirium, and pain.
- Neuropathic pain will not respond well to narcotics alone.
- Bone pain is difficult to manage with a single agent, consider using an NSAID.

Dyspnea
- Morphine is the preferred medication. It produces pulmonary vasodilatation, analgesia, and euphoria and will help to decrease dyspnea in low dosages (1-5mg IV or 5-10 mg PO q4hours). If the patient is already on an opiate drip, there is potential to develop respiratory tolerance that may require a 25-50% increase to manage dyspnea.
- Oxygen may or may not be helpful. For some patients a mask will increase a sense of claustrophobia and anxiety. Patient’s wishes should be considered.
- Avoid suctioning when possible. May decrease secretions by limiting IV hydration and using Scopolamine Patch or Atropine.

Delirium
- Initial dosage is often required every 30-60 minutes until the patient is calm. May require q4-6 hours. Maximum Haldol should not exceed 3mg/24 hours.
- Severe agitation may require additional use of benzodiazepines such as Ativan for sedation.
- Consider dose alterations for geriatric patients and those experiencing renal or hepatic failure.

Care of the Dying
- Exquisite clinical assessment skills on an ongoing basis are required for maximal symptom management.
- Patients and their families need to feel they will not be abandoned. Compassionate care requires listening and presence.
- Discuss goals with patients and families as they approach EOL. Support hopes, alleviate fears.
- Pay attention to subtle cues. Each patient and family will want to receive information in their own way, some directly and others not at all.
- Be mindful of cultural/spiritual traditions that may become important at this time.
# Disaster Planning

## Expectant-Comfort Care Medication List

### Per 12 Hour Shift

### Pain
- Morphine 5mg PO  
  100 Doses
- Morphine 10 mg PO  
  100 Doses
- Morphine 15 mg PO  
  100 Doses
- Morphine 100 mg/100 ml IV  
  x 10
- Morphine 2mg IV  
  x 40
- Morphine 4mg IV  
  x 40
- Hydromorphone 50 mg/50 ml  
  x 10
- Hydromorphone 0.5 mg IV  
  x 20

### Nausea/Vomiting
- Prochlorperazine 25 mg PR  
  x 10
- Ondansetron 4mg IV  
  x 20

### Anxiety
- Lorazepam 1mg PO  
  x 20
- Lorazepam 1mg IV  
  x 40

### Delirium
- Haloperidol 1 mg IM  
  x 20
Terminal Congestion

Scopalamine Transdermal 1.5mg x20
Atropine 2 gtts SL x 20 bottles

4-5 Boxes of saline flush syringes
Disaster Management for the Expectant/Palliative Care Triage Program

All patients that come in to the hospital following a disaster, and die as a result of their injuries while in the hospital need to be treated as a Coroners Case. All bodies of the deceased need to have the following:

- Any and all personal belongings and identifying materials need to be kept with the patient at all times including clothes, phones, valuables and any identifying materials.
- If no family is available at the time of death, any clothing and identifying features (wallets/purses/phones) should be bagged and labeled and placed inside the body bag with the patient.
- All patients who die as a result of injury due to a disaster need to be phoned in to the Coroner’s Office and reported and a coroner’s case number obtained.
- A Form 18 must be completed on all these deaths.
- Follow the hospital protocol for coroners cases

Coroner’s Office # to report a death : 1(323)343-0711

(Contact for further information: Brian Elias, Captain of investigations: 323-343-0733)
A PHYSICIAN, FUNERAL DIRECTOR OR OTHER PERSON SHALL IMMEDIATELY NOTIFY THE CORONER WHEN HE HAS KNOWLEDGE OF A DEATH WHICH OCCURRED OR HAS CHARGE OF A BODY IN WHICH DEATH OCCURRED:

a. Without medical attendance.
b. During the continued absence of the attending physician.
c. Where the attending physician is unable to state the cause of death.
d. Where the deceased person was killed or committed suicide.
e. Where the deceased person died as a result of an accident.
f. Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

Section 27941 of the Government Code, State of California

It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden or unusual deaths; unattended deaths; deaths wherein the deceased has not been attended by a physician in the 20 days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicides, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure or starvation, acute alcoholism, drug addiction, strangulation, aspiration, or where the suspected cause of death is sudden infant death syndrome; deaths in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational disease or occupational hazards; deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of Mental Health; deaths of patients in state hospitals serving the developmentally disabled and operated by the Developmental Services; deaths under such circumstances as to afford a reasonable ground to suspect that death was caused by the criminal act of another, or any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner. Inquiry in this section does not include those investigative functions usually performed by other law enforcement agencies.

In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death. If the death occurred in a state hospital, the coroner shall forward a copy of his report to the state agency responsible for the state hospital.

The coroner shall have discretion to determine the extent of inquiry to be made into death occurring under natural circumstances and falling within the provisions of this section, and if inquiry determines that the physician of record has sufficient knowledge to reasonably state the cause of death occurring under natural circumstances, the coroner may authorize that the physician to sign the certificate of death.

Listed below are types of death which have been difficult to evaluate and should be referred to the Coroner for decision:

- Aspiration – refer to Coroner
- Suffocation – refer to Coroner
- Drug addiction – refer to Coroner
- Exposure – refer to Coroner
- Pneumococcalis – refer to Coroner

Gastroenteritis
a. Do not use as cause of death. If death a result of "Acute Hemorrhagic Enteritis of unknown natural causes," it is not cause for the Coroner.
b. Refer all others to the Coroner because of possibility of poisoning.

Gastrointestinal hemorrhage
a. Do not use as cause of death. If death a result of "Gastrointestinal hemorrhage of undetermined natural causes," it is not cause for the Coroner.
b. Refer all others to the Coroner.

Heat prostration – refer to Coroner.

Diarrhea – should not be used as immediate cause of death.

Fractures
a. All fractures should be evaluated by the Coroner except SPONTANEOUS PATHOLOGICAL fractures.

Therapeutic misadventure – refer to Coroner

Operative Deaths (result of surgery or anesthesia) – refer to Coroner.

CONTAGIOUS DISEASES

A coroner's referral will not be necessary for diagnosed cases of contagious diseases since local procedures and action by the Health Department after notification will be the defense against public hazard.

Cases of possible but not diagnosed contagious disease, such as, possible meningitis or possible pulmonary tuberculosis when an autopsy is not contemplated, shall be referred to the coroner for diagnosis following which notification of proper authorities will be made.