Carvalho, Antonio S.
92 year old Male

MRN: **2312121**
Date of Birth: **7/1/1933**

Agency Information

Southcoast Visiting Nurse Association Inc.
200 Mill Road
Fairhaven, MA 02719-5252
Ph: 508-973-3200
Fx: 508-973-3417

Plan of Care (1108688) Submitted

Hospice Plan of Care Recertification 7/6/25

Plan ID: 311706

Effective from: 7/6/2025 Effective to: 10/3/2025

Participants as of Finalize on 7/9/2025

Name	Type	Comments	Contact Info
Robert J Caldas, DO	Attending Provider		508-996-3991
Pam Shea, RN	Case Manager, Skilled Nursing		
Susan Connery	Clergy		
Erica Ortell, LICSW	Medical Social Work		
Cynthia Chandanais-Wajda, RN	Skilled Nursing		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Plan of Care Notes

Skilled Nursing note by Pam Shea, RN Last edited by Pam Shea, RN on 7/2/2025 1:27 AM EDT

This is the second Hospice benefit period for 92 year old patient of Dr. R. Caldas", with primary hospice diagnosis of CVA

Related Comorbidities: Dementia, CVA, prostate cancer, subclinical hypothyroidism, and multiple falls.

Code Status/ MOLST:
Currentlya Full Code
POC includes:
- SN: weekly
- MSW 1 x/month
- Spiritual Care 1-2 x/month
- HHA 2 x/week
- Volunteer n/a

Pain is a 0/10 on the numeric scale

PPS:
On admission/last recert: 40 %
Now: 30 %
NYHA (If applicable)
On admission/last recert: n/a
Now:
FAST (If applicable)
On admission/last recert: 7 B
Now: 7 B
Weight:

On admission/last recert: 177 pounds
Now: unable to assss--pt is too unsteady
MAC:
On admission/last recert: LUA 26 cm.
Now: LUA 26cm.
Intake and appetite
On admission/last recert: good
Now: good
Medication Changes and Impact
Ativan 0.5 mg at night for sleep
Medication Reconciliation completed: yes
Bowel regimen: Senna s daily
Braden score: was 16 on adm--now 14
DME: Manual Wheel Chair and Walker covered by Hospice
Patient remains eligible to receive hospice services due to (describe physical/functional/cognitive decline): Pt in increasingly unsteady-He slides to the floor frequently--He has sustained no injuries, but ther is increased potential for an injury to occur.m, -It takes 2 persons at times to transfer pt--pt denies pain-His appetite is good--BM's are regulated with senna S-Pt is incontinent of urine and bowel-Pt does not exhibit any signs of pain-Pt does receive Tylenol infrequently, for an occasional headache-pt requires max assistance with bathing, toileting, dressing, and eeding. Pt's speech is sometimes repetative and can often be nonsensical. Pt was not sleeping well, but since the inception of 0.5 mg Ativan,in the last 3 weeks, coupled with Melatonin, pt is sleeping better. Pt's skin is intact.Pt is able to swallow without coughing--He does have crackles in his lung bases. He is not short of breath.Pt's dementia contributes to the complexity of the Late Effects of his CVA. Pt's increased musculoskeletal weakness , places him at increased risk of falls. SN cvontinuie to visit pt weekly--assess cvp, gi, gu, safety, comfort-Family knows to call with changes, concerns.

Progress toward patient/family goals: Remain comfortable/safe athome
Hospice Attending Dr. Caldas patient/decision maker and IDT attendees aware of hospice recertification and in agreement with POC.
Patient/caregivers aware to call SCVNA with any questions, concerns or changes in condition.

Diagnoses as of 7/9/2025

Diagnoses	ICD-10-CM	ICD-9-CM	Hospice Related
(P) CVA (cerebral vascular accident) (HCC)	I63.9	434.91	Related
HLD (hyperlipidemia)	E78.5	272.4	Related
GERD (gastroesophageal reflux disease)	K21.9	530.81	Unrelated
Subclinical hypothyroidism	E03.8	244.8	Unrelated
BPPV (benign paroxysmal positional vertigo)	H81.10	386.11	Unrelated
Dementia (HCC)	F03.90	294.20	Unrelated
Generalized anxiety disorder	F41.1	300.02	Unrelated
Falls	R29.6	V15.88	Unrelated
History of prostate cancer	Z85.46	V10.46	Unrelated

Allergies as of 7/9/2025

No Known Allergies

Medications

Prescriptions and Patient-Reported

Name	Dispense	Refills	Start Date	End Date	Hospice Coverage
acetaminophen (TYLENOL) 650 MG suppository Sig: Insert 1 suppository (650 mg total) into the rectum every 6 (six) hours as needed for mild pain (1-3) or fever Route: Rectal	—	—	4/5/2025	—	Covered
acetaminophen 500 MG tablet Sig: Take 1,000 mg by mouth every 8 (eight) hours as needed for fever or mild pain (1-3). Do not exceed 6 tablets per day Route: Oral	—	—	6/12/2025	—	Covered
amLODIPine (NorVASC) 2.5 MG tablet Sig: Take 1 tablet (2.5 mg total) by mouth daily Route: Oral	30 tablet	0	3/9/2025	4/8/2025	Covered
aspirin 81 MG EC tablet Sig: Take 1 tablet (81 mg total) by mouth daily Route: Oral Not Covered Reason: a. Not related to hospice diagnosis	30 tablet	0	3/8/2025	4/7/2025	Not Covered
bisacodyl 10 MG suppository Sig: Insert 1 suppository (10 mg total) into the rectum daily as needed for constipation Route: Rectal	—	—	4/5/2025	—	Covered
clopidogrel 75 MG tablet Sig: Take 75 mg by mouth daily. Route: Oral Not Covered Reason: e. Would be covered IF switched to a Hospice formulary medication.	—	—	4/7/2025	—	Not Covered
haloperidol 2 mg/mL oral solution concentrate Sig: Take 0.5 mL (1 mg total) by mouth every 6 (six) hours as needed for agitation Route: Oral	—	—	4/5/2025	—	Covered
hyoscyamine (ANASPAZ) 0.125 MG tablet Sig: Place 1 tablet (0.125 mg total) under the tongue every 4 (four) hours as needed (for secretions) Route: Sublingual	—	—	4/5/2025	—	Covered
LORazepam (ATIVAN) 0.5 MG tablet Sig: Take 1 tablet (0.5 mg total) by mouth every 6 (six) hours as needed for anxiety (or agitation) Route: Oral	—	—	4/5/2025	—	Covered
melatonin 5 MG tablet Sig: Take 5 mg by mouth at bedtime as needed for sleep. Route: Oral	—	—	5/1/2025	—	Covered
morphine sulfate 20 MG/ML concentrated oral solution Sig: Take 0.25 mL (5 mg total) by mouth every 3 (three) hours as needed (severe pain or resp distress) Oral or SL Max Daily Amount: 40 mg Route: Oral	—	—	4/5/2025	—	Covered
prochlorperazine (COMPAZINE) 10 MG tablet Sig: Take 1 tablet (10 mg total) by mouth every 6 (six) hours as needed for nausea or vomiting Route: Oral	—	—	4/5/2025	—	Covered
sennosides-docusate sodium 8.6-50 MG per tablet Sig: Take 2 tablets by mouth daily. Route: Oral	—	—	4/7/2025	—	Covered

Durable Medical Equipment as of 7/9/2025

Name	Start Date	End Date	Hospice Coverage	Not Covered Reason	Comments
Other (specify)	4/7/2025	—	Covered	—	lift chair, over the bed table
Manual wheelchair	4/7/2025	—	Covered	—	—
Four wheeled walker	—	—	—	—	—

Planned Visits

Clergy

Visits	Dates
1 to 2 visits every month for 3 months Comments: Prayer-Spiritual Support	7/6/2025 to 9/30/2025
1 to 2 visits as needed Comments: Prayer-Spiritual Support at EOL	7/6/2025 to 10/3/2025

Home Health Aide

Visits	Dates
2 visits every week for 13 weeks	7/6/2025 to 10/3/2025
Comments: Assistamnce with Pesonal Care Needs	

Medical Social Work

Visits	Dates
1 to 2 visits every month for 3 months	7/6/2025 to 9/30/2025
Comments: MSW visits for emotional support, companionship, and CG support to improve coping	
1 to 3 visits as needed	7/6/2025 to 10/3/2025
Comments: additional CG/crisis/resources support	

Skilled Nursing

Visits	Dates
1 visit every week for 12 weeks	7/6/2025 to 9/27/2025
7 visits as needed	7/6/2025 to 10/4/2025
Comments: assess changes in neuro status, cvp, gi, gu, comfort, safety-decline in health status	
1 visit every 6 days for 6 days	9/28/2025 to 10/3/2025

Problems

All Disciplines

Problem: Fall Prevention

All Disciplines Starting: 4/7/2025
At Risk for Falls - Fall Prevention

Goal: Demonstrate ability to follow strategies minimizing fall risk; verbalize fall risk awareness due to meds/sensory deficits and environmental factors.

All Disciplines Starting: 4/7/2025
Patient will demonstrate safe gait with or without a device.Through 10/03/25

Intervention: Assess and Instruct on Appropriate Use of Devices/Equipment

All Disciplines Starting: 4/7/2025 Frequency: Each Visit
walker

Intervention: Assess and Instruct on Physiological Fall Risk Factors and Prevention

All Disciplines Starting: 4/7/2025 Frequency: Each Visit
pain

Intervention: Assess/Instruct Regarding Fall Risk Factors and Prevention

All Disciplines Starting: 4/7/2025 Frequency: Each Visit
keep necessities within reach such as telephone, commode, snacks, beverages, etc

Intervention: Assist patients in setting up daily notes/alarms for meds. Consider pill box use.

All Disciplines Starting: 5/16/2025 Frequency: Each Visit

Intervention: Other

All Disciplines Starting: 5/16/2025 Frequency: Each Visit
Primary caregiver to use sensor alarm while patient is seated in chair or bed

Problem: Infection Prevention/Precautions

All Disciplines Starting: 4/7/2025
Infection prevention/Precautions

Goal: Understanding universal/standard precautions and proper handling/disposal of infectious materials. Patient/caregiver will be protected from exposure by maintaining universal/standard precautions in the home.

All Disciplines Starting: 4/7/2025
Maintain universal/standard precautionsThrough 10/03/25

Intervention: Assess Risk For Infection

All Disciplines Starting: 4/7/2025 Frequency: Each Visit
Respiratory compromise

Intervention: Instruct

All Disciplines Starting: 4/7/2025 Frequency: Each Visit
Frequent and proper handwashing.

Clergy

Problem: Spiritual Needs

Clergy Starting: 4/11/2025
Spiritual Plan

Goal: The spiritual needs of patients, caregivers and significant others will be supported.

Clergy Starting: 4/11/2025
To spiritually strengthen the Pt and family through commendation prayer, Anointing of the Sick, and presence while assisting the Pt with preparing for end of life, reinforcing his faith and coming to a place of peace through recert period ending 10/3/25.

Intervention: Assist in Spiritual Practices
Clergy Starting: 4/11/2025 Frequency: Each Visit
Such as prayer and readings

Intervention: Contact Clergy of Faith Community
Clergy Starting: 4/11/2025 Frequency: Each Visit

Intervention: Give Time, Actively Listen
Clergy Starting: 4/11/2025 Frequency: Each Visit

Intervention: Provide Grief Support
Clergy Starting: 4/11/2025 Frequency: Each Visit

Intervention: Provide Spiritual Support
Clergy Starting: 4/11/2025 Frequency: Each Visit
to pt, caregivers, family and supportive friend(s)

HHA

Problem: Home Health Aide

HHA Starting: 4/7/2025
Alteration in ADLs/IADLs

Goal: Provide HHA services which are reasonable and necessary with patient/caregiver verbalizing satisfaction with services.

HHA Starting: 4/7/2025
HHA will provide safe and appropriate care in maintaining patient hygiene through 10/03/25

Intervention: Assist With Bathing
HHA Starting: 4/7/2025 Frequency: Each Visit
tub/shower/sink

Intervention: Make Bed/Change Linens As Requested
HHA Starting: 4/7/2025 Frequency: Each Visit

Intervention: Other
HHA Starting: 4/7/2025 Frequency: Each Visit
light housework if time allows

Intervention: Place Items Within Patient's Reach
HHA Starting: 4/7/2025 Frequency: Each Visit
such as phone, beverage, snack, commode

Intervention: Report Skin Redness/Open Areas to HCP
HHA Starting: 4/7/2025 Frequency: Each Visit

MSW

Problem: Altered environmental/safety status

MSW Starting: 4/24/2025
thru 10/3/25

Goal: Patient has safe environment to promote adequate and effective care.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Assess Patient/Caregiver/Family'S Ability to Maintain a Safe Environment.
MSW Starting: 4/24/2025 Frequency: Each Visit

Goal: Patient will have effective and adequate care to promote a safe environment.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Assist Patient/Caregiver/Family With Arrangements for a Positive, Safe Living Environment

MSW Starting: 4/24/2025 Frequency: Each Visit

Goal: Patient/Caregiver will verbalize alternative plans for care when no longer able to care for self/patient.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Assist Patient/Caregiver/Family With Arrangements for a Positive, Safe Living Environment

MSW Starting: 4/24/2025 Frequency: Each Visit

Problem: Altered mental/emotional status

MSW Starting: 4/24/2025
thru 10/3/25

Goal: Patient/caregiver/family demonstrates improved coping skills and reduced stress.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Identify and Support Effective Coping Stategies.

MSW Starting: 4/24/2025 Frequency: Each Visit

Goal: Patient/caregiver/family feels supported and confident with expectations of end-of-life care and the dying process.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Provide Reassurance, Companionship, and Comfort to Patient/Caregiver/Family.

MSW Starting: 4/24/2025 Frequency: Each Visit

Goal: Patient/caregiver/family utilizes effective communication to promote positive patient care.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Instruct Patient/Caregiver/Family on Importance of Positive Communication

MSW Starting: 4/24/2025 Frequency: Each Visit

Goal: Patient/caregiver/family verbalize emotions, feelings, thoughts and concerns to decrease and/or resolve stress and increase positive coping during care.

MSW Starting: 4/24/2025
through 10/3/25

Intervention: Assess/Monitor Patient/Caregiver/Family's Coping/Emotional Status

MSW Starting: 4/24/2025 Frequency: Each Visit

Intervention: Provide caregiver with coping/stress relief strategies

MSW Starting: 4/24/2025 Frequency: Each Visit

Intervention: Provide strategies/resources to reduce stress

MSW Starting: 4/24/2025 Frequency: Each Visit

SN

Problem: Advance Directives

SN Starting: 6/30/2025
Advanced Directives

Goal: Documentation of Advanced Directives will be attained following education, support and discussion with patient/caregiver(s).

SN Starting: 6/30/2025
Full code status at present reflect HCP's wishes for pt through 10/03/25

Intervention: Other

SN Starting: 6/30/2025 Frequency: Each Visit
as pt's health status declines, HCP will agree to DNR

Intervention: Teach patient/family about Advance Directives
SN Starting: 6/30/2025 Frequency: Each Visit

Problem: Alzheimers/Dementia
SN Starting: 4/7/2025
Alteration in Neuro Status- Alzheimers, Dementia

Goal: Caregiver will verbalize and demonstrate effective care giving and reporting of appropriate symptoms to MD including but not limited to changes in nutrition, hydration, skin integrity, dysphagia, medication, GI/GU and psychosocial issues.
SN Starting: 4/7/2025
Caregiver will verbalize symptoms to be reported to MD including issues with nutrition, hydration, skin integrity, dysphagia, medications, GI/GU & psychosocial.Through 10/03/25

Intervention: Assess Caregiver
SN Starting: 4/7/2025 Frequency: Each Visit
coping

Intervention: Assess Patient For
SN Starting: 4/7/2025 Frequency: Each Visit
mood and affect

Intervention: Assess need for HCA
SN Starting: 4/7/2025 Frequency: Each Visit

Problem: Cardiac
SN Starting: 4/7/2025
Alt in Cardiac Status-CHF,HTN, other Cardiac disease

Goal: Patient/caregiver will verbalize and demonstrate understanding of disease management, avoiding ED visits/rehospitalizations and following appropriate measures during a cardiopulmonary exacerbation.
SN Starting: 4/7/2025
Pt/caregiver will verbalize/demonstrate effective management of cardiac disease including steps to take with exacerbation
Through 10/03/25

Intervention: Assess and Instruct on the Risk Factors of Hypertension
SN Starting: 4/7/2025 Frequency: Each Visit

Problem: Cardiopulmonary General
SN Starting: 4/7/2025
Alteration in Cardiopulmonary status

Goal: Consistent assessment of general cardiopulmonary function with appropriate modifications to treatment as needed.
SN Starting: 4/7/2025
Pt/caregiver will demonstrate/verbalize appropriate steps to take with cardiopulmonary exacerbationThrough 10/03/25

Intervention: ASSESS VS
SN Starting: 4/7/2025 Frequency: Each Visit
vitals and O2 sat each SNV as tolerated

Intervention: Assess and Instruct on Self-Management of Respiratory Symptoms
SN Starting: 4/7/2025 Frequency: Each Visit
management of dyspnea

Problem: End of Life Care
SN Starting: 4/7/2025
End of Life Care

Goal: Provide ongoing caregiver support/education with caregivers demonstrating appropriate care of the dying patient with well managed symptoms and a comfortable death process.
SN Starting: 4/7/2025
Caregivers will be supported and demonstrate appropriate care of the dying patient Through 10/03/25

Intervention: Assess Elimination Needs

SN Starting: 4/7/2025 Frequency: Each Visit
need for a Foley catheter

Intervention: Assess Physical Symptoms

SN Starting: 4/7/2025 Frequency: Each Visit
Need for oxygen

Intervention: Assess Psychosocial Status

SN Starting: 4/7/2025 Frequency: Each Visit
coping

Intervention: Comfort Kit Instruction

SN Starting: 4/7/2025 Frequency: Each Visit
including storage, medications, use and to call hospice prior to opening

Intervention: Conversion of Medication Routes

SN Starting: 4/7/2025 Frequency: Each Visit
from oral, sublingual, G-tube, J-tube, NG tube, rectal, vaginal, topical, nasal spray, suppository or gel as changes in the patient's condition warrant.

Intervention: Instruct in End of Life Process

SN Starting: 4/7/2025 Frequency: Each Visit
natural hydration methods

Intervention: Other

SN Starting: 4/7/2025 Frequency: Each Visit
Hospice Standing Orders:

- MD Notice: You may make any changes necessary. You will be notified of any changes that occur to the patient's plan of care (POC). If medications are needed for on-going treatment, you will be contacted for a cont inuing order.
- An order will be sent for signature when any of these are instituted.

Bowel Management Protocol

- All patients who are prescribed opioid therapy will be placed on a bowel regimen.
- Docusate Sodium (Colace) 100mg by mouth three times daily upon initiation of opioid therapy.
- If constipation develops- may give Docusate Sodium (Colace) 200 mg by mouth twice daily, up to 6 tabs daily
- If resistant, progress to Docusate/Senna 50/8.6 mg (Senna-S) 2 tablets twic e daily as needed for persistent Constipation, up to 6 tabs daily
  - Mild persistent constipation give Docusate/Senna 50/8.6mg 2 tablets by mouth twice daily, up to 6 tabs daily
  - Moderate persistent constipation give Docu sate/Senna 50/8.6 mg 2 tablets by mouth three times daily, up to 6 tabs daily
- Miralax (polyethylene glycol) 17g (one capful) dissolved in 4 to 8 ounces of liquid once daily
- Bisacodyl (Dulcolax) 5 mg tablet by mouth daily as neede d- or may use
- If no BM in three days,
  - Magnesium Hydroxide (Milk of Magnesia) 30 mls by mouth at bedtime as needed
  - If no effect may progress to Bisacodyl Suppository 10mg per rectum daily in the morning as n eeded
  - If no effect and patient does not have leukemia/MDS, may progress to Fleets Enema per rectum once daily as needed

If Patient Unable to Tolerate Tablets May Convert to Following Protocol

- Lactulose 10 grams/15mls -give 15 m l by mouth daily for mild constipation or prevention as needed
- Lactulose 10 grams/15mls- give 15 ml twice daily by mouth for moderate constipation as needed
- Lactulose 10 grams/15mls-give 15ml three times daily for severe constipation a s needed if refractory:

- Citrate of Magnesia ½ bottle daily by mouth for moderate constipation as needed
- Citrate of Magnesia 1 bottle daily by mouth for severe constipation as needed
- Fleet enema daily as needed if poor muscle tone

A cute Diarrhea Protocol
- Loperamide 4mg (2 caplets) by mouth after first unformed stool followed by 1 caplet/2mg after each unformed stool as needed.
  - If no effect progress to Loperamide 4 mg (2 caplets) four times daily until diarrhea is relieved, daily dose not to exceed 8 tablets in 24 hours

  OR

- Lomotil 2.5 mg/0.025 mg tablet, 2 tablets by mouth after first unformed stool 4 times daily until diarrhea is controlled. Max dosing 20 mg/day. Discontinue if no improvement within 10 days after treatment with max dosing.

Nausea/Vomiting Management Protocol
- Prochlorperazine (Compazine) 10mg every 6 hours by mouth prn or 25mg rectally every eight hours as needed.
- If persistent may prog ress to Haloperidol (Haldol) 0.5mg by mouth every four hours as needed for mild nausea and vomiting.
- Haloperidol (Haldol) 1mg by mouth every four hours as needed for moderate nausea and vomiting

Pain Protocol
Bone Pain/Mild Pain
- I buprofen 200 mg by mouth - 2 tablets- 400mg -every six hours as needed for mild bone pain- not to exceed 2400mg/day
- Ibuprofen 600 mg every six hours as needed for moderate bone pain – not to exceed 2400 mg/day
  OR
- Acetaminoph en 650 mg by mouth every six hours as needed for mild bone pain-up to 3000mg /day

Neuropathic Pain, mild moderate or severe
- Gabapentin (Neurontin) 100 mg by mouth every night x three nights
- If after three days still experiencing neuropat hic pain proceed to Gabapentin 100 mg by mouth twice daily for three days
- If still experiencing neuropathic pain proceed to Gabapentin 100 mg by mouth three times daily
  - If persistent:
    - Mild
      - Gabape ntin (Neurontin) 200 mg by mouth three times daily, 600 mg max daily
    - Moderate
      - Gabapentin (Neurontin) 400 mg by mouth three times daily, 1200 mg max daily
    - Severe
      - Gabapentin (Neurontin) 600 mg by mouth three times daily, 1800 mg max daily

Visceral Pain (Soft Tissue)
- Call MD / NP for a combination opioid if opioid naïve

Seizure
- Phenobarbital 60 mg suppository every 8 hours, consult with attending for long term plan

Delirium/Terminal Restlessness

- Haloperidol (Haldol) 1mg by mouth every four hours as needed for Mild unrelieved symptoms
- Haloperidol (Haldol) 2mg by mouth every four hours as need ed for Moderate unrelieved symptoms
- Haloperidol (Haldol) 4mg by mouth every four hours as needed for Severe unrelieved symptoms

If persistent unrelieved terminal restlessness
- Lorazepam (Ativan) 0.5mg by mouth every four hours as need ed for mild terminal restlessness
- Lorazepam (Ativan) 1 mg by mouth every four hours as needed for moderate terminal restlessness, 6 mg max daily

Anxiety
- Lorazepam (Ativan) 0.5mg by mouth every four hours as needed for Mild Anxiety
- Lorazepam (Ativan) 1 mg by mouth every four hours as needed for Moderate anxiety, up to 6 mg daily
- Lorazepam (Ativan) 2 mg by mouth every four hours as needed for severe anxiety, up to 12 mg daily

Fever Protocol- Temperature greater t han 100.4 F
- Acetaminophen (Tylenol) 650 mg by mouth or per rectum every six hours as needed for temperature greater than 100.4. If no effect may progress.
- Ibuprofen 400 mg by mouth every six hours as needed for temperature greater than 100.4 F.

Terminal Secretions Protocol
- Hyoscyamine (Levsin) 0.125 mg by mouth or sub lingual every four hours as need for management of mild secretions
- Hyoscyamine (Levsin) 0.25mg by mouth or sub lingual every four hours as needed fo r the management of moderate to severe secretions.
- Glycopyrrolate (Robinul) 1 mg by mouth or sublingual three times daily scheduled as needed for secretions.

Respiratory Distress Management Protocol
- Oxygen 2 liter via nasal cannula -intermittent or continuously for symptoms of mild respiratory distress
- Oxygen 3 liters via nasal cannula- intermittently or continuously for relief of moderate respiratory distress
- Oxygen 4 liters via nasal cannula- intermittently or continuously for relief of severe respiratory distress
- If respiratory rate 28 or more, may give Roxanol 5 mg SL x 1 dose, with immediate call to physician to get a medication order, then add it to medication list/orders.

Bladder Manag ement Protocol
- Foley #16 - #18 catheter with 5cc to 10cc balloon as needed for management of urinary incontinence. Change indwelling Foley Catheter every three months and as needed.
  - Changing indwelling catheters or drainage bag s at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. (CDC)
- Texas catheter as needed for male patient. If not effective may progress to Foley catheter

Urinalysis Protocol
- May collect urine for UA, with reflex to culture.

Problem: General Skin / Integumentary
SN Starting: 4/7/2025

Alteration in Integumentary status (actual and/or risk for)

Goal: Free from integumentary complications; able to demonstrate interventions/dietary measures to promote healthy skin.

SN Starting: 4/7/2025

Pt/caregiver will verbalize/demonstrate pressure relief measures, repositioning, need to keep skin clean and dry, dietary measures to promote healthy skin and rationale for interventions Through 10/03/25

Intervention: Assess and Instruct on Risk of and on Methods to Prevent Skin Breakdown

SN Starting: 4/7/2025 Frequency: Each Visit

Pressure relief techniques

Problem: Pain

SN Starting: 4/7/2025

Alteration in comfort- Pain

Goal: Achieve acceptable levels of pain, independence with strategies for breakthrough pain and symptoms to report to HCP.

SN Starting: 4/7/2025

Acceptable level of pain will be achievedThrough 10/03/25

Intervention: Assess Effectiveness of Pain Medications

SN Starting: 4/7/2025 Frequency: Each Visit

Assess effectiveness of pain medication each visit until acceptable level is achieved, including over the counter medications.

Intervention: Assess and Instruct on Patient's Level of Pain Using Appropriate Pain Scale

SN Starting: 4/7/2025 Frequency: Each Visit

Using pain scale every visit until acceptable level is achieved

Episode Summary as of 7/9/2025

Election Date	Effective Date	Code Status	Code Status Comments	Triage Code	Place of Service
4/7/2025	4/7/2025	Full Code	—	Medium risk	28 Donald St South Dartmouth MA 02748-1902

Benefit Periods as of 7/9/2025

#	Start Date	End Date	Verbal CTI Date	Certifying Hospice Physician	Attending Physician
1	4/7/2025	7/5/2025	4/7/2025	Mark Shparber, MD	Robert J Caldas, DO
2	7/6/2025	10/3/2025	7/1/2025	Mark Shparber, MD	Robert J Caldas, DO

Participants as of 7/10/2025

Name	Type	Comments	Contact Info
Robert J Caldas, DO Signature pending	Attending Provider		508-996-3991
Pam Shea, RN	Case Manager, Skilled Nursing		
Susan Connery	Clergy		
Erica Ortell, LICSW	Medical Social Work		
Cynthia Chandanais-Wajda, RN	Skilled Nursing		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Plan of Care Order Detail

Provider Details

Plan of Care Order Detail (continued)

Authorizing Provider	Last Event	Reviewer	Address
Robert J Caldas, DO	Submit	Lianna G Tibbetts, RN	531 FAUNCE CORNER RD HAWTHORN MEDICAL ASSOC. NORTH DARTMOUTH MA 02747

Entered By

Lianna G Tibbetts, RN at 7/9/2025 9:22 AM

Order Date

7/9/2025 9:22 AM

Provider Comments

Provider Signature for Robert J Caldas, DO

Signature:_____ Date:_____

Order ID for Carvalho,Antonio S.

1108688