

Diabetic Ketoacidosis Admit Orders

CHECK BOX TO ACTIVATE ORDER

<p>ADMISSION INFORMATION</p> <p>Ht: _____</p> <p>Wt: _____</p>	<p>Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____</p> <p>Secondary diagnosis: _____</p> <hr/> <p>Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____</p> <p>Admit to <input type="checkbox"/> ICU (See Critical Care Authorization Sheet)</p> <p>Code Status: (See Goldenrod)</p> <p>Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown</p>
<p>REFERRALS</p>	<p><input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Dysphagia <input type="checkbox"/> Wound/Ostomy Care RN</p> <p><input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____</p> <p>Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture</p> <p><input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Music Care <input type="checkbox"/> Osteopathy</p>
<p>NURSING CARE</p>	<p>VS: <input type="checkbox"/> Per Unit protocol <input type="checkbox"/> every _____ hour(s)</p> <p><input type="checkbox"/> Foley <input type="checkbox"/> I&O <input type="checkbox"/> Weigh daily</p> <p>Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> Turn patient every 2 hours <input type="checkbox"/> BRP <input type="checkbox"/> OOB to chair every _____ <input type="checkbox"/> Ambulate as tol.</p> <p><input type="checkbox"/> Notify physician if: HR <60 or >120 ■ SBP <80 or >160 ■ DBP >100 ■ RR <8 ■ Temp >101.5</p> <p>■ SpO2 <90% ■ Urine Output <20 ml/hr X 2 hours</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: ■ HR < _____ or > _____ ■ SBP < _____ or > _____ ■ DBP < _____ or > _____</p> <p>■ RR < _____ or > _____ ■ Temp > _____ ■ SpO2 < _____ % ■ Urine Output < _____ ml/hr</p>
<p>LAB</p>	<p><input type="checkbox"/> On admit (if not done in ED): <input type="checkbox"/> CBC <input type="checkbox"/> Manual diff <input type="checkbox"/> CMP <input type="checkbox"/> CPK, Troponin, Myoglobin (if patient older than 40 years) <input type="checkbox"/> Serum acetone <input type="checkbox"/> Blood cultures X 2</p> <p><input type="checkbox"/> Magnesium –and replace per K+ and Mg+ protocol</p> <p><input type="checkbox"/> Phosphorus – if phosphorous < 1.5, call physician for replacement orders <input type="checkbox"/> UA with culture if indicated</p> <p><input type="checkbox"/> ABG <input type="checkbox"/> Hemoglobin A1C <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> BMP and Magnesium every 4 hours until anion gap less or equal to 12</p> <p><input type="checkbox"/> AM Labs: CBC, CMP, magnesium, phosphorus,</p>
<p>X-RAY</p>	<p><input type="checkbox"/> Portable CXR if not done in ER and repeat in AM</p>
<p>DIETARY</p>	<p><input type="checkbox"/> NPO <input type="checkbox"/> Clear liquids <input type="checkbox"/> ADA _____ Cal <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Nutrition consult and education</p>
<p>RESPIRATORY CARE</p>	<p><input type="checkbox"/> EKG if not done in ER; notify physician of ST-segment elevation or new LBBB</p> <p><input type="checkbox"/> SpO2 <input type="checkbox"/> Every shift <input type="checkbox"/> With room air ambulation <input type="checkbox"/> O₂ to maintain SpO₂ ≥ 93%</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</p> <p><input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p>OR</p> <p><input type="checkbox"/> Albuterol 90 mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) MDI 0.5mg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation</p>
<p>INFECTION PREVENTION</p>	<p><input type="checkbox"/> Isolation Precautions—for: _____</p> <p>MRSA LEGAL REQUIREMENTS:</p> <p><input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>ADMIT</u> if: Discharged from an acute care hospital within past 30 days; OR Transferred from a nursing facility; OR Admission to ICU (one screen per hospital stay)</p> <p><input type="checkbox"/> Positive MRSA History—Do not test. Start Glove Precautions.</p> <p><input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>DAY OF DISCHARGE</u> if Palm Drive LOS > 10 days AND patient was in ICU.</p> <p>CULTURES: <input type="checkbox"/> wound <input type="checkbox"/> aspiration closed wound <input type="checkbox"/> sputum (PNA) <input type="checkbox"/> U/A with UTI symptoms/Hx <input type="checkbox"/> Blood</p> <p>DIARRHEA: (3 or more unformed stools in past 24 hours)—NOTIFY I.P. x4386 and send stool for C-Difficile</p> <p>Other etiologies: <input type="checkbox"/> Bacterial (stool culture) <input type="checkbox"/> Norovirus <input type="checkbox"/> Parasites x3 (O&P) rate <input type="checkbox"/> Other: _____</p>
<p>PEPTIC ULCER PROPHYLAXIS</p>	<p><input type="checkbox"/> Famotidine (Pepcid) 20 mg PO/IV BID</p> <p><input type="checkbox"/> Pantoprazole (Protonix) 40 mg PO/IV daily</p>

Palm Drive Hospital

Diabetic Ketoacidosis Admit Orders

IV	<input type="checkbox"/> One-time bolus infusion of 20 ml/kg NS, then: <input type="checkbox"/> 0.9% NaCl at _____ml/hour <input type="checkbox"/> 0.45% NaCl at _____ml/hour <input type="checkbox"/> Add Dextrose 5% to current infusion once blood glucose less than 250mg/dl <input type="checkbox"/> Add 30 mEq KCL to liter of infusion once serum K below 5.5, as long as UOP > 50ml/hr and serum CR < 2.0 mg/dL
----	--

Diabetic Ketoacidosis

Admit Orders

VTE Prophylaxis	PATIENT CATEGORY / RISK FACTORS	RISK	PROPHYLAXIS METHOD				
	Patient is < 40 years old & no additional risk factor (See High Risk below)	LOW	<input type="checkbox"/> No specific measures; early ambulation				
	Patient 40-60 years with limited mobility and no additional risk factor (see High risk below)	MOD	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose OR <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days				
	Patient >60 yrs or any risk factor such as: CHF, MI, resp. failure, trauma (major or lower extremity), cancer, infection, restricted mobility, ICU admit, obesity, surgery, varicose veins, prior DVT/PE, chronic lung disease, inflammatory bowel disease, smoking, HRT use, pregnancy current or recent.	HIGH	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose PLUS <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days				
	Contraindications to anticoagulation therapy <ul style="list-style-type: none"> • No mechanical prophylaxis due to: <ul style="list-style-type: none"> <input type="checkbox"/> bilateral amputee <input type="checkbox"/> lower extremity trauma • No anticoagulation at this time due to: <ul style="list-style-type: none"> <input type="checkbox"/> pharmacological VTE prophylaxis: <input type="checkbox"/> platelet count <100,000/mm <input type="checkbox"/> on warfarin prior to admit <input type="checkbox"/> active bleeding (GI bleed) <input type="checkbox"/> cerebral hemorrhage <input type="checkbox"/> retroperitoneal bleeding <input type="checkbox"/> lumbar puncture within 24 hrs <input type="checkbox"/> epidural cath within 24 hours <input type="checkbox"/> hypersensitivity to Heparin or Enoxaparin. <input type="checkbox"/> patient refusal <input type="checkbox"/> other: _____ 	E X C E P T I O N	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose				
GLYCEMIC CONTROL	<input type="checkbox"/> Regular insulin: (Goal to Maintain Blood Glucose 140-180mg/dl) <ol style="list-style-type: none"> 1. Bolus: Regular insulin 0.15 units/kg IV 2. Infusion: 100 units regular insulin/100 ml normal saline—begin at 0.1 unit/kg/hour 3. Regulate infusion to decrease blood glucose by 25-50 mg/dl/hr. If blood glucose decreases by greater than 100mg/dl/hr, decrease infusion rate by half. 4. If blood glucose increases by: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">100-199 mg/dl increase insulin drip by 1 Unit/hr</td> <td style="width: 50%;">200-299mg/dl increase Insulin drip by 2 Units/hr</td> </tr> <tr> <td>300-399 mg/dl increase insulin drip by 3 Units/hr</td> <td>>400 mg/dl – Call physician for order</td> </tr> </table> 5. Obtain FSBS every 1 hour <p style="text-align: center;">Do not reduce insulin below 0.01 units/kg/hr until serum HCO₃ greater than 22</p>			100-199 mg/dl increase insulin drip by 1 Unit/hr	200-299mg/dl increase Insulin drip by 2 Units/hr	300-399 mg/dl increase insulin drip by 3 Units/hr	>400 mg/dl – Call physician for order
100-199 mg/dl increase insulin drip by 1 Unit/hr	200-299mg/dl increase Insulin drip by 2 Units/hr						
300-399 mg/dl increase insulin drip by 3 Units/hr	>400 mg/dl – Call physician for order						
ANTIBIOTICS	See "Empiric Antibiotic Guidelines" <input type="checkbox"/> _____						
PAIN	<input type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO/PR every 4 hours PRN mild pain ($\leq 3/10$), temp greater than 101°F <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 1 tab PO every 4 hours PRN mild to moderate pain ($< 5/10$) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 2 tabs PO every 4 hours PRN moderate to severe pain ($\geq 5/10$) <input type="checkbox"/> MORPHINE Sulfate _____ mg IV every 2 hours PRN pain $\geq 5/10$ or NPO						
NAUSEA/ VOMITING	<input type="checkbox"/> Prochlorperazine (Compazine) 10mg PO every 6 hrs or 25mg supp every 12 hrs PRN nausea <input type="checkbox"/> Dolasetron (Anzemet) 12.5mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Metoclopramide (Reglan) 10mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Ondansetron (Zofran) 4mg IV every 6 hrs PRN nausea or vomiting						

Palm Drive Hospital

Diabetic Ketoacidosis Admit Orders

BOWEL CARE	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate (DSS 250 mg PO daily MOM 30 ml PO daily PRN constipation	Biscodyl (Dulcolax) Supp PR daily PRN constipation Fleets Enema daily PRN constipation
SLEEP	<input type="checkbox"/> Temazepam (Restoril) 15mg PO every HS PRN insomnia MR X1 in 1 hour <input type="checkbox"/> 7.5 mg(rec. for ≥65 years) <input type="checkbox"/> ZOLDIPEM (Ambien) 5mg PO HS PRN insomnia MR X1 in 1 hour	
VACCINES	Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol	
OTHER ORDERS	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Physician Signature: _____ Date: _____ Time: _____		
Transcriber Signature: _____ Date: _____ Time: _____		