

PULMONARY EMBOLISM 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><input type="checkbox"/> M/S <input type="checkbox"/> Telemetry (see Telemetry Standing Orders) <input type="checkbox"/> ICU (see Critical Care Authorization Sheet)</p> <p>Secondary diagnoses: _____</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____</p> <p>Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical</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 _____ hours</p> <p>I&O daily <input type="checkbox"/> weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion</p> <p><input type="checkbox"/> Reposition patient every 2 hours</p> <p>Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> BSC <input type="checkbox"/> OOB to chair at least _____ daily <input type="checkbox"/> Amb as tol. <input type="checkbox"/> _____</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><input type="checkbox"/> Notify physician if O₂ flow needs to be increased by more than 2 liters/minute to maintain SaO₂ > 90%.</p> |
| <p>LAB</p> | <p>On Admit (if not done in ED) <input type="checkbox"/> CBC <input type="checkbox"/> Manual differential <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> U/A <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> D-Dimer <input type="checkbox"/> PT <input type="checkbox"/> PTT</p> <p><input type="checkbox"/> Protein C&S <input type="checkbox"/> Antithrombin III <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Lupus Anticoagulant</p> <p><input type="checkbox"/> AM Labs: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> PT/TNR <input type="checkbox"/> PTT <input type="checkbox"/> Other: _____</p> |
| <p>X-RAY</p> | <p><input type="checkbox"/> CXR <input type="checkbox"/> Bilateral ultrasound of legs to R/O DVT</p> <p><input type="checkbox"/> Spiral chest CT with Contrast to R/O pulmonary emboli</p> <p><input type="checkbox"/> Ventilation/Perfusion Lung Scan to R/O pulmonary emboli (not done at Palm Drive)</p> |
| <p>DIETARY</p> | <p><input type="checkbox"/> Dietary Consult <input type="checkbox"/> NPO <input type="checkbox"/> Clear Liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Regular <input type="checkbox"/> _____ Gm Sodium</p> <p><input type="checkbox"/> _____ Calories ADA <input type="checkbox"/> Encourage fluids</p> <p><input type="checkbox"/> Other: _____</p> |
| <p>RESPIRATORY CARE</p> | <p>SpO2 <input type="checkbox"/> every shift <input type="checkbox"/> every am <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> EKG; notify</p> <p><input type="checkbox"/> O2 to maintain SaO2 at >92% or _____ %</p> <p><input type="checkbox"/> DC O2 if SaO2 after ½ hr on room air > 90% (Recent MI>95%)</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</p> <p>Hand Held Nebulizer (HHN)</p> <p><input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropin (Atrovent) 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropin/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Xopenex 1.25mg by HHN _____ hours PRN SOB, wheezing, or desaturation</p> <p>OR</p> <p><input type="checkbox"/> Albuterol 90mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropin (Atrovent) MDI 0.5mg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropin/Albuterol (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Advair _____ mcg/_____ mcg by DPI, 1 puff BID for SOB, wheezing, or desaturation.</p> <p><input type="checkbox"/> Spiriva 1 capsule (18mcg) by DPI daily for SOB, wheezing, or desaturation</p> |

PULMONARY EMBOLISM ADMIT ORDERS

| | | | |
|--|---|--|---|
| INFECTION PREVENTION | <input type="checkbox"/> Isolation Precautions—for: MRSA LEGAL REQUIREMENTS: <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). <input type="checkbox"/> Positive MRSA History—Do not test. Start Glove Precautions. <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>DAY OF DISCHARGE</u> if Palm Drive LOS > 10 days AND patient was in ICU. 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 DIARRHEA: (3 or more unformed stools in past 24 hours)—NOTIFY I.P. x4386 and send stool for C-Difficile Other etiologies: <input type="checkbox"/> Bacterial (stool culture) <input type="checkbox"/> Norovirus <input type="checkbox"/> Parasites x3 (O&P) rate <input type="checkbox"/> Other: | | |
| ANTI-COAGULATION | <input type="checkbox"/> Use "Heparin IV Dosage Chart" Draw baseline PT/PTT Heparin 80 units/kg IV bolus (maximum of 10,000 units regardless of weight) Followed by maintenance infusion of Heparin 25,000 units/250 ml start at 17 units/kg/hr- see Chart A Order next PTT in 6 hours after starting infusion and after each rate adjustment -adjust Heparin rate per Chart B Once PTT level is therapeutic, PTT will be tested daily with AM lab draw; Heparin to be adjusted as needed. OR <input type="checkbox"/> Lovenox 1 mg/kg subQ every 12 hours; dosing adjustment per pharmacy | | |
| WARFARIN (COUMADIN) | <input type="checkbox"/> 5mg PO nightly AFTER HEPARIN HAS BEEN STARTED <input type="checkbox"/> Daily Protime while on Coumadin | | |
| 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 • No mechanical prophylaxis due to: <input type="checkbox"/> bilateral amputee <input type="checkbox"/> lower extremity trauma • No anticoagulation at this time due to: <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"/> CVA <input type="checkbox"/> retroperitoneal bleeding <input type="checkbox"/> bleeding risk <input type="checkbox"/> HIT <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 |
| NOTE: Therapeutic treatment may negate need for VTE | | | |
| IV | <input type="checkbox"/> Saline Lock <input type="checkbox"/> _____ to run at _____ ml/hour <input type="checkbox"/> PICC consult/protocol | | |

