

Sepsis Admit Orders

Check box to activate order

ADMISSION INFORMATION Ht: _____ Wt: _____	Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Med-Surg <input type="checkbox"/> ICU (see Critical Care Authorization Sheet) <input type="checkbox"/> Tele (see Telemetry Standing Orders) Diagnosis: Sepsis Secondary Diagnoses: _____ Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____ Code Status: (See Goldenrod) Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown
REFERRALS	<input type="checkbox"/> Infectious Disease <input type="checkbox"/> Discharge Planning <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Dysphagia <input type="checkbox"/> Wound/Ostomy Care RN <input type="checkbox"/> Financial Services <input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____ Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Music Care <input type="checkbox"/> Osteopathy
NURSING CARE	VS per unit protocol <input type="checkbox"/> VS every ____ hour(s) <input type="checkbox"/> I&O Weigh daily <input type="checkbox"/> Foley catheter—UA dip to Lab with insertion <input type="checkbox"/> Place Feeding tube – Type _____ <input type="checkbox"/> Notify physician if: <input checked="" type="checkbox"/> HR < 50 or > 150 <input checked="" type="checkbox"/> SBP < 90 or > 180 <input checked="" type="checkbox"/> DBP < 30 or > 110 <input checked="" type="checkbox"/> RR < 5 or > 40 <input checked="" type="checkbox"/> Temp > 101 F <input checked="" type="checkbox"/> SpO2 < 85% <input checked="" type="checkbox"/> Urine Output < 20 ml/hr X 2 hours OR <input type="checkbox"/> Notify physician if: <input checked="" type="checkbox"/> HR < ____ or > ____ <input checked="" type="checkbox"/> SBP < ____ or > ____ <input checked="" type="checkbox"/> DBP < ____ or > ____ <input checked="" type="checkbox"/> RR < ____ or > ____ <input checked="" type="checkbox"/> Temp > ____ <input checked="" type="checkbox"/> SpO2 < ____% <input checked="" type="checkbox"/> Urine Output < ____ ml/hr Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> BRP <input type="checkbox"/> OOB to chair every _____ <input type="checkbox"/> Ambulate as tolerated Reposition patient every 2 hours
LAB	On Admit: (if not done in ED) <input type="checkbox"/> CBC <input type="checkbox"/> Manual diff <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> ABG <input type="checkbox"/> D-Dimer (DIC Panel) <input type="checkbox"/> Lactate <input type="checkbox"/> U/A <input type="checkbox"/> Urine culture <input type="checkbox"/> Troponin <input type="checkbox"/> CPK <input type="checkbox"/> Mg <input type="checkbox"/> Sputum Gm Stain and C&S <input type="checkbox"/> Blood Culture x 2 different sites (collect before antibiotics) <input type="checkbox"/> Other Culture: _____ <input type="checkbox"/> Other: _____ AM Labs: <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Mg <input type="checkbox"/> ABG <input type="checkbox"/> Other: _____
X-RAY	<input type="checkbox"/> CXR PA/ Lat <input type="checkbox"/> CXR Portable AP <input type="checkbox"/> Other: _____
DIETARY	<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 <input type="checkbox"/> _____ Calories ADA <input type="checkbox"/> Tube feeding _____
RESPIRATORY CARE	<input type="checkbox"/> SpO2 <input type="checkbox"/> every shift <input type="checkbox"/> every am <input type="checkbox"/> with ambulation on room air <input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB <input type="checkbox"/> O2 @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____% Incentive Spirometer 5-10 times every 1-2 hours WA <input type="checkbox"/> Cough and deep breathe every 2 hours WA <input type="checkbox"/> CPT every _____ <input type="checkbox"/> Suction _____ <input type="checkbox"/> BIPAP: RR _____ I _____ cm E _____ cm @ _____ liter/min and initiate BIPAP protocol <input type="checkbox"/> Vent (see Ventilator Orders) <input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation <input type="checkbox"/> Ipratropium 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation <input type="checkbox"/> Albuterol/Ipratropium(Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation OR <input type="checkbox"/> Albuterol 90mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation <input type="checkbox"/> Ipratropium MDI 17mcg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation <input type="checkbox"/> Albuterol/Ipratropium (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation
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: _____

NOTE: EMPIRIC ANTIBIOTIC ORDERS to be attached to this order set.

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IV	PICC consult/protocol <input type="checkbox"/> Saline Lock <input type="checkbox"/> D5%NS Rate: <input type="checkbox"/> 150ml/hr or <input type="checkbox"/> _____ ml/hr or <input type="checkbox"/> _____ at <input type="checkbox"/> 150ml/hr or <input type="checkbox"/> _____ ml/hr <input type="checkbox"/> 2 IV lines		
ANTIBIOTICS	Antibiotics must be ordered on "Empiric Antibiotic Orders" order set Antibiotics within 1 hour of admission (after blood cultures have been drawn)		
SEPSIS CARE (ONLY IN ICU)	If MAP < 60: 1. NS 1000 ml IV up to CVP 8-12 mmHg 2. If refractory, start Dopamine drip. Titrate up to 30/mcg/kg/min to achieve MAP>60 3. If refractory, start Norepinephrine drip. Titrate up to 30mcg/min to achieve MAP>60 4. If refractory, start Vasopressin drip at 0.01 units/min. Titrate up to 0.04 units/min to achieve MAP>60 If Urine Output < 0.5ml/kg/hr x 2 hrs Give NS 500 ml IV bolus (if CVP < 12 mmHg) If SVO2 < 70% 1. Transfuse: 1 unit PRBC for Hct 26-29 OR 2 units PRBC for Hct ≤ 25 (H&H 1 hr post transfusion) 2. If unable to keep SVO2 > 70%, start dobutamine at 5mg/kg/min. Titrate up to 20mg/kg/min <input type="checkbox"/> Hydrocortisone 100mg IV every 8 hrs x 7 days		
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
PEPTIC ULCER PROPHYLAXIS	<input type="checkbox"/> Famotidine (Pepcid) 20 mg PO/IV BID <input type="checkbox"/> Pantoprazole (Protonix) 40mg PO/IV daily		
GLYCEMIC CONTROL	<input type="checkbox"/> Notify physician for fasting AM blood sugar > 140 <input type="checkbox"/> Sliding Scale Insulin (see order sheet) or <input type="checkbox"/> Intensive Insulin Protocol (ICU only - see order sheet)		
PAIN	<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO/PR every 4 hours PRN mild pain (3/10 or less), temp greater than 38.5° C (max daily dose Tylenol = 4 gms) <input type="checkbox"/> Hydrocodone/Acetaminophen 5mg/325 mg (Norco) 1 tab PO every 4 hours PRN for mild to mod pain (<than 5/10) <input type="checkbox"/> Hydrocodone/Acetaminophen 5mg/325 mg (Norco) 2 tabs PO every 4 hours PRN for mod-severe pain (≥5/10) <input type="checkbox"/> Morphine Sulfate 4mg IV every 2 hours PRN for pain(≥ 5/10) or NPO		

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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
BOWEL CARE	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate Sodium (Colace) 250 mg PO daily Bisacodyl (Dulcolax) Supp 10 mg PR daily PRN constipation Milk Of Magnesia 30 ml PO daily PRN constipation Fleet Enema daily PRN constipation
ANXIETY	<input type="checkbox"/> Alprazolam (Xanax) 0.25 mg PO every 6 hours PRN anxiety OR <input type="checkbox"/> Lorazepam (Ativan) _____ mg IV / PO (circle one) every _____ hrs PRN anxiety
SLEEP	<input type="checkbox"/> Temazepam (Restoril) 15mg PO every HS PRN insomnia MR X1 in 1 hour if needed <input type="checkbox"/> Temazepam (Restoril) 7.5 mg (recommended for ≥65 years) PO every HS PRN insomnia MR X1 in 1 hour if needed <input type="checkbox"/> Zolpidem (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"/> Multivitamin with minerals 1 tab PO daily <input type="checkbox"/> PPD <input type="checkbox"/> PPD with Candida control (HIV expected) <input type="checkbox"/> Magnesium/Aluminum Hydroxide/Simethicone (Maalox) 30 ml PO every 4 hours PRN indigestion <input type="checkbox"/> Nicotine Patch: <input type="checkbox"/> 7 mg daily <input type="checkbox"/> 14 mg daily <input type="checkbox"/> 21 mg daily <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: _____	

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