1-2006

Patient Care News: January 2006

St. Cloud Hospital

PATIENT CARE NEWS

Volume 27, Number 1 **St. Cloud Hospital, St. Cloud, MN** **January 2006**

INSIDE THIS ISSUE:

ATTACHMENTS:

- Pneumonia CMS "Core Measures" form
- COPD form
- Heart Failure (CHF) CMS "Core Measures" form
- Ischemic Stroke form
- Alcohol Withdrawal form

Translated Patient Education Materials

Before you invest hours and dollars in translating patient education materials into other languages (Spanish, Hmong, Laotian or Somali), check out the resources already translated on the CentraNet under the Patient Care, Education or Diversity tab named "Translated Patient Education Materials."

Over 75 documents including consents, diseases, medications, treatment options, and dialysis procedures have been translated into different languages and are available just a telephone call away. Check it out!

Pam Rickbeil, RN
Education

Educational and Professional Development Programs

February, 2006

7 Cardiology Seminar (The Power of Walking; Taking Steps to Build a Healthier, More Livable Community) Community event
7 Cardiology Seminar, Windfeldt
10/17 BLS Instructor NEW Course

March, 2006

22/23 Emergency Nursing Pediatric Course, Conference Center
28 Endoscopy Conference, Windfeldt Room
28/29 ONS Cancer Chemotherapy Course, Fireside Room/Aspen Room
28/29 Trauma Nursing Core Course, Conference Center

For more details, call the Education Department at Ext. 55642.

Magnet Force #9 – Autonomy

Description: Nurses are permitted and expected to practice autonomously, consistent with professional standards. Independent judgment is expected to be exercised within the context of a multidisciplinary approach to patient care.

We are looking for:

- Direct care RNs (at least 50% of the time spent at the bedside) using professional standards, literature and research findings to support control over nursing practice
- How nurses use independent decision making, assertiveness and leadership in the patient care environment.
- How changes in practice are supported by professional standards, literature and research.
- How patient care outcome issues are identified by direct care RNs and how they were addressed.

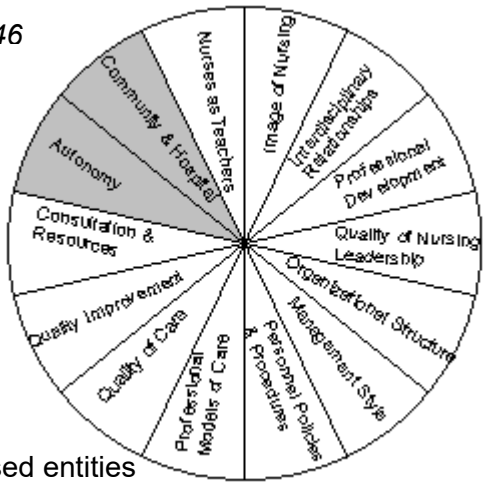
Force #9 – Force Leaders

Anne Gagliardi, RN, BSN
Surgery
Ext. 55618

Joy Plamann, RN, BSN
MPCU
Ext. 53546

Magnet Force #10 – Community and Hospital

Description: St. Cloud Hospital has a strong community presence in ongoing, long term outreach programs with SCH perceived as a strong, positive, productive corporate citizen. Development and support of strong partnerships among all types of healthcare organizations for improved patient outcomes and the health of the community.



We are looking for stories and examples about:

- List of partnerships established between SCH and community based entities to advance nursing practice.
- List of partnerships established between SCH and community-based entities to meet the healthcare needs of populations served.
- Examples of awards or recognition's received by the facility or any nurses for community support or involvement.
- Examples of programs and outcomes that have resulted from nursing collaborations/partnerships with other nursing entities in the community or region.

Force #10 – Force Leader

Carolyn Neubauer
Educator
Emergency Trauma Center
Ext: 57298

New "Medical/Critical Care Admission Orders" and "Evidence - Base" Protocols will be Implemented:

JANUARY 3, 2006

Several months ago a multi-discipline group met to streamline admission orders that are currently available for medical patients and to revise select "pre-printed" orders into protocols. This work has resulted in a **Medical/Critical Care Admission Order *(attached)* and 5 Evidence-Based Protocols. These protocols are:**

1. **Pneumonia** CMS **"Core Measures"** incorporated *(see attached)*
2. **COPD** *(see attached)*
3. **Heart Failure (CHF)** CMS **"Core Measures"** incorporated *(see attached)*
4. **Ischemic Stroke** *(see attached)*
5. **Alcohol Withdrawal** *(see attached)*

In July, 2005 the Hospitalist group began to trial the admission order set and protocols. After completion of this trial, feedback was reviewed by nursing staff, HUC's and physician groups. Final revisions were brought to the Medical Executive Committee and Department of Medicine in November, 2005 with final approval to implement.

These orders/protocols are currently **"not mandatory",** but highly ENCOURAGED.

- ***"What happens to the Pre-printed Orders?"***

  EFFECTIVE JANUARY 3, 2006:
  PRE-PRINTED ORDERS for Pneumonia, COPD, Heart Failure (CHF), and Alcohol Withdrawal and ADMISSION ORDERS for Critical Care, Nephrology, and Stroke **WILL BE DELETED FROM JRS OPTIO AND CENTRANET.**

- ***"What responsibilities does the physician have when ordering protocols?"***

  Physicians are responsible for knowing what is included on the protocol they select. If a physician does not want a particular order, they need to **line through the order.**

- ***"What do I look for in JRS OPTIO?"***

  1. **Medical Admission Non Critical- Care**
     This will print with a medical admission order sheet.

  2. **Medical Admission Critical Care**
     This will print with 2 order sheets medical admission and critical care admission.

  3. **Critical Care Admission**
     This will print a critical care admission order to be used for In-house transfers.

- ***"Do I need a physician signature on the protocol?"***

  Currently, at the time of admission, the nurse will write a VORB/physician _____. The physician will need to sign the order during the patient's stay or after discharge.

Ongoing education will be completed for Critical Care, Telemetry, Med/Onc., Ortho/Neuro, ETC and Float Pool by their representatives prior to implementation. There will also be weekly reminders in JRS up to implementation.

Thank you to all committee members, nursing staff, and physicians who gave of their time and participated with this project. A special thanks to Deb Wimmer, Diane Gustafson, Robin Sass, and Michelle Parson who were instrumental in facilitating the operational steps necessary.

Deb Eisenstadt, MS, RN
Clinical Utilization Specialist
Ext. 54169

~ Please See Attachments ~

Pertussis and the Healthcare Setting

With the rise in reported cases of pertussis in Minnesota (see "Pertussis Vaccines for Adolescents and Adults and Updated Treatment and Prophylaxis Recommendations on p. 67) has come an increase in the reported transmission of the disease within the healthcare setting. Pertussis transmission from patient to provider and vice versa, including large outbreaks in healthcare facilities, has been documented in Minnesota and nationally.

Recent Minnesota Department of Health (MDH) investigations of pertussis transmission in a hospital neonatal intensive care unit and in an obstetrics clinic were particularly concerning, as infants are at the highest risk for severe and potentially fatal pertussis-related complications. By promptly recognizing cases, notifying patients, and providing prophylaxis to close contacts, health officials and healthcare facility staff may have prevented secondary cases.

In addition to posing health risks, pertussis is costly when it occurs in healthcare workers because of lost work time and the considerable resources required for the notification and prophylaxis of other staff and patients. Recently, an outbreak of pertussis occurred in a Minnesota healthcare facility, resulting in 17 confirmed cases in employees. Onsets of the illness developed over a 2-month period and involved three clusters within the facility, causing a tremendous expenditure of time, energy, and money to control the spread of the illness. Over the course of the outbreak, 687 employees were provided antimicrobial prophylaxis, and 510 patients were notified of possible pertussis exposure. The situation also contributed to pertussis transmission in the community, as at least one healthcare provider transmitted pertussis to his/her child, and at least one pertussis transmission in a childcare setting was linked to the hospital outbreak.

Prevention in the Healthcare Setting

Pertussis is spread by droplets containing *Bordetella pertussis* bacteria. The droplets generally travel no more than 3 feet from the infected patient and are deposited on the new host's nasal mucosa, conjunctivae, or mouth. Droplets can be generated during coughing and sneezing, as well as during the performance of certain medical procedures such as a nasopharyngeal (NP) swab, aspirate, or wash.

Standard national guidelines state that "close contacts" of pertussis patients should be provided antimicrobial prophylaxis (See Table 1 on p. 68). While no national standard definition of "close contact" exists, MDH and local health department epidemiologists, with extensive experience conducting pertussis case investigations, have collaboratively agreed to define close contact as either 1) direct face-to-face exposure with an infectious case, or 2) exposure for at least 10 hours over a week's time, during which the individual is generally within 3 feet (i.e., arm's length) of a case.

Performing an NP swab, aspirate, or wash on an infectious pertussis patient without a surgical mask constitutes a close exposure warranting prophylaxis. Healthcare providers should take droplet precautions (i.e., standard precautions and masking) whenever working with an unknown respiratory illness. Masking during such procedures eliminates the need for post-exposure prophylaxis and also protects the healthcare worker from other respiratory illnesses.

Healthcare providers should be mindful of their own symptoms, particularly paroxysmal coughing or a cough illness lasting longer than 7 days. When a healthcare worker is diagnosed with pertussis within the first 3 weeks of the cough illness, the healthcare provider should be excluded from work until he or she has completed 5 days of appropriate antimicrobial treatment. All potentially exposed persons should be informed about pertussis symptoms and encouraged to seek medical evaluation if symptomatic, and asymptomatic close contacts should be prescribed a course of antimicrobial prophylaxis. When patients are exposed to pertussis at a healthcare facility, the facility

should assume responsibility for the cost of notification, testing, prophylaxis, or treatment, as indicated.

Need for Collaboration
Public health agencies and healthcare facilities must work collaboratively to adequately address pertussis prevention and control. Upon identifying pertussis in a patient or healthcare worker, healthcare facilities should notify public health officials for assistance in identifying close contacts and in coordinating contact notification and prophylaxis. Conversely, when MDH or local public health agencies identify a pertussis outbreak in a school or other community setting, they should notify healthcare facilities that may be affected by the outbreak.

Immunization is a primary pertussis prevention and control strategy; however, the current practice of vaccinating children younger than 7 years has not eliminated the reservoir of infection, as pertussis remains endemic despite high immunization rates. The availability of two newly licensed pertussis vaccines for older children and adults provides the opportunity to expand coverage. (See "Pertussis Vaccines for Adolescents and Adults and Updated Treatment and Prophylaxis Recommendations" on p. 67.) The Advisory Committee on Immunization Practices (ACIP) has recommended that older children and adults receive the new pertussis vaccine when they are due for a tetanus diphtheria booster. ACIP is considering recommendations for vaccinating targeted adults, including healthcare workers.

Resources
MDH has developed a number of pertussis-related information pieces targeted to both healthcare providers and the general public that address various aspects of pertussis epidemiology, laboratory testing, treatment and prophylaxis, and prevention and control measures.

These materials are posted on the MDH Web site at www.health.state.mn.us/divs/idepc/diseases/pertussis

Fay Chawla
Occupational Health Services

Clinical Ladder

Congratulations to the following individuals for achieving and/or maintaining their Level III Clinical Ladder status!

Level III

Jane Austing, RN — OR
- Revised Procedure Cards
- Preceptor
- Practice Committee
- H-Works Committee

Chelsie Baaken, RN — FBC
- Team Nursing Presentation
- Preceptor
- Employee Satisfaction Committee
- Chair of Employee Satisfaction Committee

Kristin Gaarder, RN — Surgical Care
- Taught Abdominal Surgery Class
- Preceptor
- SCRUBS Committee

Sharon Klimek, RN — KDA
- Taught Renal Failure and Treatment Options
- Coordinates Monthly Care Conferences
- PI Committee Member

Jennifer Krebsbach, RN — Imaging
- PIC Independent Learning Module
- EPIC Liaison
- Preceptor
- DVT Poster
- Med/Surg Certification

Colleen Layne, RN — CSC
- Edits Weekly Unit Newsletter
- Preceptor
- Future Planning Task Force
- Med/Surg Certification

Elaine Prom, RN — CSC
- New and Revised Standing Orders
- PI Committee
- Preceptor
- Med/Surg Certification

Jessica Lund, RN Children's Center

- PI Committee
- Co-wrote Diabetic CCO Care Plan
- EPIC Liaison
- PCW Long Range Strategic Planning

Joann Spaulding, RN Telemetry

- Carotid Stint Module
- Biphasic Defibulator External Pacemaker and Temporary Pacemaker Skill Sets

Carol Steil, RN ICU

- Nursing Process Group Leader
- Certified Donor Requestor
- Preceptor
- CCNP Committee

Nancy Stiles, RN ETC

- EPIC Liaison
- Preceptor
- Nurse Practice Committee
- Clinical Ladder Committee

Barb Wagner, RN ETC

- PI Committee
- Restraint Poster
- PALS Instructor
- Inservice on Documentation Pitfalls

St. Cloud Hospital
CENTRACARE Health System

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

PNEUMONIA PROTOCOL

- Initiate Pneumonia CCP

- Verify blood cultures x 2 drawn prior to initial antibiotic

Antibiotics: Renal Dosing Protocol Applies per Pharmacy

If Community Acquired/Nursing Home

- Levofloxacin 750 mg IV/po q 24 hours **STAT** (**Pharmacy to dispense oral dosage form unless otherwise indicated.**)

- Document smoking cessation counseling if smoked within past 12 months

- Pneumococcal Vaccine - administer if ≥ to 65 years of age and patient has not received or is unknown
- Influenza Vaccine (October - February) for patients age 50 years or older administer if patient has not received

- Sputum for Gram Stain, culture if adequate specimen

- RN Case Manager Referral

CRITICAL CARE ONLY (Per Critical Care Admission Orders)

If Aspiration Pneumonia in Critical Care

HIGH RISK FOR PSEUDOMONAS
Give three antibiotics listed below

- Cefepime 2 gm IV q 12 hrs begin **STAT**
- Tobramycin IV per Pharmacy Protocol
- Doxycycline 100 mg IV q 12 hrs

If patient allergic to cephalosporins or anaphylaxis with penicillin, then give two antibiotics listed below:

- Levofloxacin 750 mg IV q 24 hours **STAT**
- Tobramycin IV per Pharmacy Protocol

LOW RISK FOR PSEUDOMONAS
Give three antibiotics listed below

- Cefepime 2 gm IV q 12 hrs begin **STAT**
- Doxycycline 100 mg IV q 12 hrs.
  May switch to oral when able.

If patient allergic to cephalosporins or anaphylaxis with penicillin then give the following antibiotic:

- Levofloxacin 750 mg IV q 24 hours **STAT**
  May switch to oral when able.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

ORDER SHEET

Scanned (Name)_____ **(Date)**_____ **(Time)**_____

St. Cloud Hospital
CENTRACARE Health System

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

COPD EXACERBATION PROTOCOL

- Initiate COPD CCP

Medications

- Methylprednisolone sodium succinate (Solu-Medrol) 125 mg IV q 6 hrs x 4 doses, then change to Prednisone 20 mg (po) BID
- Metered Dose Inhaler (MDI): Albuterol/Ipratropium (Combivent) 2 puffs q 4 hrs while awake with spacer (if unable to perform MDI administration, change to Neb)
- Nebulizer: Albuterol/Ipratropium 2.5 mg (Duoneb) q 4 hrs while awake and q 2 hrs prn.
- **(If on Pneumonia Protocol, see above)** Sulfamethoxazole/TMP DS (Bactrim DS) (po) q 12 hrs. If sulfa or trimethoprim allergy, then Cefpodoxime 200 mg (po) q 12 hrs. If oral route not available, then Ceftriaxone 1 gram IV q 24 hrs.

- Document smoking cessation counseling if smoked within past 12 months on ITR.

- Dietician Referral per Nutrition Score on FHA.

- Pulmonary Rehab Evaluation and Treatment recommended for outpatient. RN to contact physician for order.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

ORDER SHEET **Scanned (Name)**_____ **(Date)**_____ **(Time)**_____

Department of Medicine – Revised: 12/16/2005
85-066-1 5200061
☐ ENDO ☐ KDIP ☐ ETC

Optio

Patient ID Label

St. Cloud Hospital
CENTRACARE Health System

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

HEART FAILURE PROTOCOL

- Initiate Heart Failure CCP

- Ejection fraction _____%, date measured _____.
  If never measured, order Echocardiogram (excludes patients on comfort care only).
  * Ejection fraction can be found under Cardiology tab in CDR in Echocardiogram, TEE, Nuclear Stress Test or Angiogram Reports

- For LVSD of < 40%, prior to discharge initiate:
  ACE inhibitor _____ or indicate contraindication _____.
  or
  ARB _____ or indicate contraindication _____.

  *Hold ACE inhibitor/ARB and call physician if two consecutive BP's (15 min apart) are ≤80 mmHg systolic

- Contact physician 24 hours prior to anticipated discharge if EF <40% and any of the following occur:
  1) ACE inhibitor/ARB not ordered **or**
  2) Contraindication not documented

Indicate if patient on Beta Blocker: _____
*Hold med and call physician if any one of the following occur:
Two consecutive BP's (15 min part) are ≤80 mmHg systolic
HR <50 bpm
Pause ≥2.5 seconds

- Contact physician 24 hours prior to anticipated discharge if no Beta Blocker ordered or no contraindication documented.

- Smoking Cessation Consult for history of smoking within the last 12 months.

- Heart Failure Education packet from Optio and initiate education

- Case Manager Consult regarding Heart Failure education and case management

- Dietitian Consult regarding Low Sodium Diet (2500 mg).

- 2500 mg Na Diet. Add ADA if diabetic.

- Vital Signs
  Daily Weight before breakfast (call physician after 0800 if weight up ≥ 1.5 kg overnight)
  Orthostatic blood pressure once daily (laying, sitting, and standing)

- May place Foley catheter as indicated and may discontinue when tolerating BRPs.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

St. Cloud Hospital
CENTRACARE Health System

ISCHEMIC STROKE PROTOCOL

- Initiate appropriate CCP.

- Aspirin Buffered 325 mg (po) or (R) daily. **Start within 48 hours of onset of stroke symptoms.**

- Neuro assessment per unit standards

  Vitals Signs q 2 hrs x 4, then q 4 hrs until stable, and then QID

  Neuro Assessment q 2 hrs, then q 4 hrs until stable, and then QID

  Check with physician for notification parameters

  ☐ for SBP> _____ DBP> _____ P>_____ T> _____

- Screen for safe swallow before first meal/H2O by mouth. If swallow impaired, make NPO and consult speech therapy to evaluate and treat for dysphasia. If swallow not impaired, diet as ordered.

- Elimination assessment q shift
- Bladder scan q 4-6 hrs prn, straight cath prn for volumes >500 mL or residual void volumes >200 mL.
- Foley catheter is recommended prior to TPA administration

Labs

- Lipid Profile **unless already done this admission**

- CT of head if not completed **this admission**

- 12 lead EKG if not completed **this admission**

- Consult Case Manager Stroke Center

- PT evaluation and treat for any functional deficit

- OT evaluation and treat for any functional deficit

- IV Therapy

  **Dextrose containing fluids not recommended for first 48 hrs. **Dextrose may be administered in maintenance solutions after 24 hrs, but should be avoided in bolus solutions (e.g. volume resuscitation fluids).

  Corticosteroids should be avoided if at all possible. If necessary, blood glucose should be closely monitored.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

ORDER SHEET **Scanned (Name)**_____ **(Date)**__

(Time)_____

☐ ENDO ☐ KDIP ☐ ETC
Optio

Patient ID Label

St. Cloud Hospital
CENTRACARE Health System

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

MEDICAL ALCOHOL WITHDRAWAL PROTOCOL

RN to implement Alcohol Withdrawal Assessment Flowsheet.

Reassess AM and PM for transfer to Critical Care or MPCU/SPCU or Med/Onc or MHU

Mental Health RN Case Manager consult to assess for Social Worker, CD eval, Addictionist

Labs • Mg++ each AM until within normal limits x 2 days • SGPT • PLTS

Medications:

- Initiate Adult Electrolyte Replacement Protocol
- Therapeutic multivitamin 1 (po) daily. If unable to tolerate (po) give 1 amp of multivit (IV) in maintenance IV (if no maintenance IV, contact physician)
- Thiamine 100 mg IV/IM/(po) daily x 7 days. **Send first dose orally.** RN to contact pharmacy if parenteral dose desired.
- Folic Acid 1 mg IV/(po) daily x 5 days. **Send first dose orally.** RN to contact pharmacy if parenteral dose desired.
- Lorazepam/Ativan 1-4 mg (po) q 1 hour prn per documented assessment score
- Lorazepam/Ativan 1-4 mg IV q 15 minutes prn per documented assessment score. May switch to oral when able.
- If above ineffective, may initiate
  - Lorazepam Maintenance Infusion for MPCU, SPCU, or Critical Care:

    Lorazepam 250 mg in D_5W 250 ml (1 mg/ml):
    Begin and maintain IV infusion at 2 mg/hr (max of 2 mg/hr) Decrease rate per Detoxification Score
    Breakthrough agitation: 1-2 mg IV over 1 minute every 5 minutes prn.
- Haloperidol 2-5 mg IV/IM/(po) q 4 hrs prn **(use IM only if (po) or IV route not available)**
- Discontinue Temazepam if ordered.

CRITICAL CARE ONLY

This sedation plan meets the patient's needs as identified through the pre-sedation assessment. Re-evaluation completed immediately prior to administration of sedation.
In the judgment of the attending physician:

- **Informed consent was obtained from patient/family after discussion of sedation options, risks, and alternatives or**
- **No informed consent was obtained due to medical emergency.**

Sedation Goal: Level 3-4 unless otherwise indicated; _____

1 = Patient anxious, agitated or restless.
2 = Patient cooperative, oriented and tranquil
3 = Patient asleep, brisk response to loud auditory stimulus
4 = Patient asleep, sluggish response to loud auditory stimulus
5 = Patient has no response to loud auditory stimulus, but does respond to painful stimulus
6 = Patient does not respond to painful stimuli

Loading dose only if patient has not received lorazepam prior to initial infusion.

- Calculation of dose 0.05 mg/kg x _____ (patient weight) = _____ mg
  - Lorazepam Infusion 0.05 mg/kg x _____ kg = _____ mg IV x 1 dose (maximum of 4 mg).
    May repeat every 3 minutes x 4 doses (total).
- Maintenance Infusion: Lorazepam 250 mg in D_5W 250 mL (1 mg/mL):'
  Calculate previous 1 hour dose. Start hourly rate at previous 1 hour total.
  Titration: Increase rate q 4 hrs, 10-50% as needed to meet Detoxification Score and Sedation goal.
  Bolus with lorazepam 1-4 mg IVP with each IV infusion dose increase.
  Breakthrough agitation: 1-2 mg IV over 1 minute every 3 minutes prn.
  Decrease rate per Detoxification Score and Sedation goal.
  If above treatment is ineffective, contact physician.
- **Propofol Infusion.**
  - May begin Propofol if Lorazepam Infusion not effective at dose up to 20 mg/hr.
  - Contact physician for order to mechanically ventilate patient.
- Propofol drip at 5 mcg/kg/min. Patient weight _____ kg. Increase dose by 5-10 mcg/kg/min to max of 80 mcg/kg/min.
- Once sedation goal is achieved, decrease infusion by 10-25% every 8 hrs as tolerated.
- Turn Propofol Infusion off daily and assess for continued need for sedation. Restart at 50% of previous dose and titrate prn.
- Draw baseline triglycerides and every 3 days. If triglycerides are elevated notify the physician.
- Consult Dietitian if patient is on Parenteral Nutrition.
- If Propofol Infusion continues past 3 days, review with physician.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

St. Cloud Hospital
CENTRACARE Health System

ADULT MEDICAL ADMISSION ORDERS

1. Admit to _____. Diagnosis _____ ☐ RN Case Manager

2. Implement Protocols:
☐ Pneumonia Protocol **(new infiltrate)**
☐ COPD Exacerbation Protocol **(no new infiltrate)**
☐ Heart Failure Protocol
☐ Alcohol Withdrawal Protocol
☐ Ischemic Stroke Protocol
☐ Insulin Infusion Protocol Order **(non Critical Care)**
☐ Adult Electrolyte Replacement Protocols
☐ Heparin Weight Based Protocol
☐ Renal Standing Orders
☐ Oncology Standing Orders

3. Hemodialysis on _____ (date) ☐ See Orders ☐ See PD Orders

4. Courtesy notification of patient's primary physician _____ of admission. (Ask patient.)

Consult Dr. _____ regarding _____ (diagnosis, sign, or symptom).

5. Code Status - **The patient is full resuscitation status unless the following is ordered:**
Up to the point of cardiopulmonary arrest, maximal therapeutic care will be given.
1. ☐ No resuscitation / No intubation
☐ Resuscitation measures as directed below
Resuscitation Medications (must do compressions): ☐ Yes ☐ No
Countershock: ☐ Yes ☐ No
Intubation for Respiratory Arrest ☐ Yes ☐ No
2. Patient on a No Code Blue / Do Not Resuscitate order who receive anesthesia/sedation, radiographic contrast, or having a procedure **has been informed** that he/she will receive full resuscitation.
3. Have discussed with the patient/family including all relevant facts, information, and circumstances about the resuscitation plan of care.

This section replaces the need for the No Code Blue/Do Not Resuscitate Orders.

6. Allergies: _____

7. Miscellaneous: ☐ Foley catheter or Other _____

8. Vital signs ☐ Routine ☐ Every 4 hours ☐ Orthostatics on Admit ☐ Other _____
☐ I+O ☐ Daily weight ☐ Daily weight at end of cycle for PD Patient on Cycler

9. ☐ Activity q shift and document ☐ Bedrest ☐ PT ☐ OT ☐ OOB with assist

10. Diet: ☐ NPO ☐ Regular ☐ NAS ☐ Low SAT fat ☐ ADA _____ ☐ Dialysis ☐ PD ☐ Renal ☐ Fluid Restriction _____
☐ Supplements _____ Texture: _____ Other: _____

11. Labs: ☐ Chem 8 (☐ now if not done this admission or ☐ in AM) ☐ CBC (☐ now if not done this admission or ☐ in AM)
☐ Glucometer checks _____ Other: _____

12. Diagnostic Studies: _____

13. ☐ DVT Heparin 5000 units subcut every 8 hours (0600, 1400, 2200) ***If in Critical Care, use Critical Care DVT Protocol.**
☐ Sequential Compression Stockings TEDS (☐ Thigh high ☐ Knee high)

14. ☐ Stress Ulcer Prophylaxis: Famotidine 20 mg po/IV/NG BID. **Send first dose orally**. RN to contact pharmacy if parenteral/NG dosage form desired. ***If in Critical Care, use Critical Care Stress Ulcer Protocol.**

15. IV: _____ ☐ Saline Lock

16. Medications: **Renal Dosing Protocol Applies per Pharmacy**
☐ Medications as ordered by physician on Dialysis Medication Order Sheet. **Nurse to file with Order Sheets.**
☐ All insulin orders must be written by physician (see Insulin Order Sheet)
☐ Acetaminophen 650 mg (po) or per rectum q 4 hrs prn pain or fever
☐ Temazepam 7.5-30 mg q HS prn sleep. May repeat dose in 1 hr. Max dose 30 mg. **Begin 7.5 mg for patients >70 years old.**
☐ MOM 30 ml (po) daily prn or ☐ Bisacodyl suppository (R) daily prn or ☐ TWE or Fleet enema daily prn constipation
☐ Dolasetron 12.5 mg IV q 8 hrs prn nausea
☐ O_2 prn per nasal canula to maintain sats >90%. Titrate per RT Protocol. ☐ Do not exceed _____ L/minute

17. If patient is on warfarin and followed by the CentraCare River Campus Anticoagulation Clinic, notify them (x 52823) of admission.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____

ALLERGY ☐ NO ☐ YES WT._____(kg.) HT._____
IF YES, PLEASE STATE_____

CRITICAL CARE ADMISSION ORDERS

- Contact Critical Care Practice Nurse if on Intensivist Service pager # 229-6438 or cell phone # 250-9630.
- Daily Goal Sheet at bedside.
- If on Mechanical Ventilation, initiate Vent Bundle.
- Medications:
  - Flush peripheral access with Normal Saline flush 2 mL q 8 hrs
  - **If patient has central line,** flush unused ports with Heparin 100 units/mL to each unused port daily

PROTOCOLS:

- **Deep Vein Thrombosis Prophylaxis Protocol**
  Exclusion Criteria for Heparin Administration
  - Active bleeding
  - Hypersensitivity to Heparin or Low Molecular Weight Based Heparin
  - INR > 1.5
  - Intracranial surgery within 6 weeks
  - Intraocular surgery within 6 weeks
  - Uncontrolled Hypertension diastolic BP >110 mmHg or systolic BP > 200 mmHg
  - Spinal tap or epidural anesthesia within 7 days
  - Heparin induced thrombocytopenia
  - ***MAJOR TRAUMA/CHI/Intracranial bleed***

  1. If patient has NONE of the above exclusion criteria: Administer heparin 5000 units subcutaneously q 8 hrs
  2. If patient has exclusion criteria: Place sequential compression stockings
- **Stress Ulcer Prophylaxis Protocol**
  If any of the following conditions are present, then begin Famotidine (as below).
  - Sepsis
  - Mechanical Ventilation expected or actual > 48 hrs
  - Patients with Hx of UGI ulcer and or bleed within 1 year
  - Patients receiving high dose corticosteroids defined as:
    Hydrocortisone > 250 mg per day
    Prednisone > 60 mg per day
    Methylprednisolone > 50 mg per day
  - Patients currently receiving NSAIDs
  - Patients with Glasgow Coma Scale <10
  - Brain or Spinal Cord Injury Patients
  - Coagulopathy: platelet count < 50,000 mm^3
    INR > 1.5

  Famotidine 20 mg (po)/IV/NG BID (if authorized above).
  - Pharmacy may adjust dose per Renal Dosing Protocol
  - **If patient is allergic to famotidine or any H2 blocker medication:**
    1. Pantoprazole 40 mg (po)/IV daily if no NG present
       or
    2. Lansoprazole Oral Suspension 30 mg per NG daily
- **Anxiety/Pain Protocol**

☐ Pneumonia Protocol (**Please check one** ☐ High Risk for Pseudomonas or ☐ Low Risk for Pseudomonas
☐ Drotrecogin Alfa (Xigris) Protocol
☐ Severe Sepsis Bundle
☐ Glucose Control Protocol
☐ Methylprednisolone for Acute Spinal Cord Injury Protocol

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

Signature: _____

Date: _____ **Time:** _____