**MEADOWVIEW REGIONAL MEDICAL CENTER**

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.

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| DATE | **TIME** | **PHYSICIAN’S ORDERS AND SIGNATURE** |
|  |  | I certify that the following services are medically necessary |
|  |  | □ Inpatient | □ Outpatient – initiate observation services |
|  |  | Sepsis Admission ADULT (page 1 of 7) |
|  |  | (all orders with a □ must be checked to be activated) |
|  |  | 1. **Admit:** □ Medical Floor □ ICU □ Telemetry
 |
|  |  | 1. **Attending Physician:**
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|  |  | 1. **Diagnoses Requiring Admission:**
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|  |  | 1. **Condition:**
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|  |  | 1. **Nursing:**

□ Vital Signs every 15 minutes until stable, then every, \_\_\_1 hour, \_\_\_ 2 hours, \_\_\_ 4 hours□ Activity: \_\_\_ Bedrest, \_\_\_ Bedrest w/ BRP, \_\_\_ Up to chair for meals, \_\_\_ Dangle, \_\_\_ OOB w/Assist□ Ambulate□ Ambulate with assist; frequency \_\_\_\_\_□ Elevate HOB 30 degrees. *May use reverse trendelenburg if patient is unable to bend at waist*□ Nasotracheal suctioning per protocol *(Separate suctioning set ups for oral and endotracheal suctioning)*□ Insert NG tube, connect to suction \_\_\_ Intermittent \_\_\_ Continuous Obtain weight in kilograms on admission and then dailyIntake & Ouput every 8 hoursContinuous Cardiac monitoring with Telemetry□ Oxygen \_\_\_ via nasal cannula, at 2 liters/min \_\_\_ via non-rebreather mask ifO2 sat <93%□ Pulse oximetry \_\_\_continuously \_\_\_ every morning \_\_\_ PRN \_\_\_ with VS, notifyMD if oxygen saturation is less than 93%□ Arterial line pressure monitoring□ Central venous pressure monitoring□ Fingerstick blood glucose x1, call LIP if result >150 to initiate insulin orders□ Blood glucose monitoring \_\_\_ before meals and at bedtime \_\_\_ every \_\_\_hours□ Precautions \_\_\_ Standard \_\_\_ Airborne \_\_\_Droplet \_\_\_Contact (reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Fall Risk Precautions□ Insert Foley Catheter□ Insert 2 large gauge peripheral IV lines |
|  |  |  Saline flush as needed |
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|  |  |  **🡻 PATIENT ID 🡻** |
|  |  | **PHYSICIAN’S ORDERS AND SIGNATURE** |
|  |  | I certify that the following services are medically necessary |
|  |  | **Sepsis Admission ADULT (page 2 of 7)** |
|  |  | (all orders with a □ must be checked to be activated) |
|  |  | 1. **IV Fluids:**

*For patients with sepsis and septic shock, fluid management should be guided using specific targets. The optimal target to guide fluid management is a MAP greater or equal to 65 mmHg and urine output greater or equal to 0.5 mL/kg/hour. Other measures of determining adequacy of fluid administration could include CVP 8 to 12 mmHg or dynamic predictors of fluid responsiveness.***Crystalloid-Fluid Bolus: (Evidence suggests volume of crystalloid bolus is 30 ml/kg)**□ Normal saline bolus 30 mL/kg administered at \_\_\_\_\_ mL/hr□ Lactated Ringers bolus 30 mL/kg at \_\_\_\_\_ mL/hr**Maintenance Crystalloid-Fluid Orders**□ Normal saline at \_\_\_\_\_ mL/hr□ Lactated Ringers at \_\_\_\_\_ mL/hr |
|  |  | 1. **Medications: Antibiotics**

*Administer broad spectrum antibiotics within 1 hour of recognition of sepsis symptoms (after cultures have been drawn)****Pulmonary/Community Acquired Pneumonia:***□ cefTRIAXone (Rocephin) 1 gm IV every 24 hours ***PLUS***□ Azithromycin (Zithromax) 500 mg IV every 24 hours***Urinary Acquired:***□ cefTRIAXone (Rocephin) 1 gm IV every 24 hours***Hospital or Healthcare Associated Pneumonia; or Unknown Source; or Skin/Soft Tissue:***□ Piperacillin-tazobactam (Zosyn) 3.375 gm IV every 6 hours **OR**□ Cefepime (Maxipime) 2 gm IV every 12 hours**PLUS**□ Vancomycin 20 mg/kg/dose IV x 1 dose, then Pharmacy to dose***Intra-abdominal Acquired:***□ cefTRIAXone (Rocephin) 1 gm IV every 24 hours **PLUS**□ metroNIDAZOLE (Flagyl) 500 mg IV every 8 hours***For Double Pseudomonas Coverage:***□ Piperacillin-tazobactam (Zosyn) 3.375 gm IV every 6 hours **OR**□ Cefepime (Maxipime) 2 gm IV every 12 hours**PLUS**□ Gentamicin 5 mg/kg IV every 24 hours, Pharmacy to dose***For Penicillin AND Cephalosporin Allergy:***□ Aztreonam (Azactam) 2 gm IV every 8 hours **PLUS**□ metroNIDAZOLE (Flagyl) 500 mg IV every 8 hours **PLUS**□ Vancomycin 20 mg/kg/dose IV x 1 dose, then Pharmacy to dose***For Documented ESBL:***□ Meropenem (Merrem) 1 gm IV every 8 hours |
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|  |  |  (all orders with a □ must be checked to be activated) |
|  |  | ***Antifungals:******(****Risk factors for candidemia: immunocompromised or neutropenic state, prior intense antibiotic therapy, or colonization in multiple sites)*□ Fluconazole (Diflucan) 800 mg IV X 1 dose STAT□ Fluconazole (Diflucan) 400 mg IV every 24 hours |
|  |  | 1. **Medications: Vasopressors – Inotropes:**

*For patients who remain hypotensive following intravascular volume repletion, vasopressors are recommended.* ***The preferred initial agent is Norepinephrine.****The target is a mean arterial pressure of 65 mmHg.*□ Norepinephrine (Levophed) at 8 mcg/minute via IV continuous infusion, titrate  until desired hemodynamic response (not to exceed 30 mcg/minute) **Recommended First Choice** □ EPINEPHrine at 1 mcg/minute via IV continuous infusion until MAP of  65-90 mmHg (not to exceed 10 mcg/minute) (*Recommended as addition to or potentially substituted for Norepinephrine when* *additional agent is needed to maintain adequate blood pressure)*□ DOBUTamine at 2.5 mcg/kg/minute via IV continuous infusion, titrate by  2 mcg/kg/minute until desired hemodynamic response (not to exceed 40 mcg/kg/minute) □ DOPamine at 5 mcg/kg/minute via IV continuous infusion, titrate by  2 mcg/kg/minute every 10 minutes until desired hemodynamic response (not to exceed 20 mcg/kg/minute) *(Alternative to Norepinephrine only in highly selective patients (e.g. patients with low risk of* *tachyarrhythmias and absolute or relative bradycardia))* □ Vasopressin at 0.03 unit/minute via IV continuous infusion until MAP of  65-90 mmHg *(Start infusion at 0.03 units/minute added to Norepinephrine with intent of raising MAP to target* *or decreasing Norepinephrine dosage. While on concomitant Vasopressin and Norepinephrine,*  *wean Norepinephrine first to maintain MAP 65-90 mmHg. Not recommended as a single initial*  *vasopressor. May use if no cardiac contraindications present.* □ Phenylephrine at 0.5 mcg/kg/minute via IV continuous infusion until MAP of 65-90 mmHg (not to exceed 10 mcg/kg/minute) **Do not use for initial therapy** (*Not recommended except in the following circumstances:* *1) Norepinephrine is associated with serious arrhythmias, 2) cardiac output is known to be high* *and blood pressure persistently low, 3) as salvage therapy when combined inotrope/vasopressor*  *drugs and low-dose Vasopressin have failed to achieve the MAP target.)* |
|  |  | 1. **Medications:**

**Stress Ulcer Prophylaxis:**□ Famotidine (Pepcid) 20 mg PO every 12 hours□ Famotidine (Pepcid) 20 mg IV every 12 hours□ Pantoprazole (Protonix) 40 mg PO daily□ Pantoprazole (Protonix) 40 mg IV daily |
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|  |  |  (all orders with a □ must be checked to be activated) |
|  |  | 1. **VTE Bundle**

|  |  |  |  |
| --- | --- | --- | --- |
| **Score 1 factor (each)** | **Score 2 factors (each)** | **Score 3 factors (each)** | **Score 4 factors (each)** |
| \_\_\_ Age > 40\_\_\_ Dehydration | \_\_\_ Age > 70\_\_\_ Major surgery > 30 min | \_\_\_ Malignancy\_\_\_ Stroke | \_\_\_ Pelvis,hip, or leg  fracture |
| \_\_\_ CHF | \_\_\_ Immobility/paralysis > 3 days | \_\_\_ Hypercoagulable status | \_\_\_ Hx of DVT/PE |
| \_\_\_ Oral Contraceptives | \_\_\_ Central venous access | \_\_\_ Severe sepsis/infection | \_\_\_ Spinal cord injury |
| \_\_\_ Obesity | \_\_\_ Immobilizing plaster cast |  | \_\_\_ Multiple trauma |
| \_\_\_ Leg edema\_\_\_ Chronic illness |  |  | \_\_\_ Total hip/knee  surgery |
| \_\_\_ HRT |  |  |  |
| \_\_\_ High-dose megestrol | **TOTAL RISK FACTOR SCORE:\_\_\_\_\_\_** |  |  |

**Low Risk (Score 0-1 factors)**□ Ambulate PRN**Moderate Risk (2 factors)**□ Antiembolism Stockings: \_\_\_ Thigh \_\_\_ Knee□ SCD, Sequential Compression Device□ Heparin 5000 units subcutaneously every 8 hours□ Enoxaparin (Lovenox) 40 mg subcutaneously every 24 hours**High Risk (3-4 factors)** TEDS, *PLUS* (check one of the following)□ Heparin 5000 units subcutaneously every 8 hours□ Enoxaparin (Lovenox) 30 mg subcutaneously every 12 hours□ Enoxaparin (Lovenox) 40 mg subcutaneously every 24 hours□ SCD, Sequential Compression Device**Highest Risk (5 or > factors)** TEDS and SCD *PLUS (check one of the following)*□ Heparin 5000 units subcutaneously every 8 hours□ Enoxaparin (Lovenox) 30 mg subcutaneously every 12 hours□ Enoxaparin (Lovenox) 40 mg subcutaneously every 24 hours**Pharmacologic/Mechanical Contraindication:**□ VTE prophylaxis contraindicated**Imaging:**□ Venous ultrasound of lower extremities, upper extremities, or bilateral extremities**Consults:**□ Pharmacy consult, warfarin RX to dose, VTE Prophylaxis |
|  |  | 1. **Therapies:**

**Lines/Catheters:**□ Arterial Catheter□ Central Venous Catheter□ PICC□ Pulmonary Arterial Catheter**Procedures:**□ Bronchoscopy |
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|  |  | 1. **Respiratory:**

*Supplemental oxygen should be supplied to all patients with sepsis and oxygenation should be monitored continuously with pulse oximetry. Intubation and mechanical ventilation may be required to support the increased work of breathing that typically accompanies sepsis, or for airway protection since encephalopathy and a depressed level of consciousness frequently complicate sepsis*.□ End-tidal carbon dioxide continuous monitoring \_\_\_\_ Timing□ Oxygen saturation continuous measurement \_\_\_ Timing□ \_\_\_ Warmed oxygen \_\_\_ Humidified oxygen \_\_\_ Oxygen Src  \_\_\_ O2 Rate , titrate to keep SpO2 greater than or equal to 92% |
|  |  | 1. **Vent Bundle**

□ HOB elevated 30 degrees□ Chlorahexidine Rinse, PRN□ Insert NG tube, Low intermittent suction, Irrigate Q4H with 30 mL H2O□ Turn pt Q2H□ Daily sedation vacation, and daily assessments of readiness to extubate |
|  |  | 1. **Laboratory**

*A serum lactate level greater than or equal to 2 mmol/L is consistent with, but not diagnostic of, severe sepsis. Additional lab studies that help characterize the severity of sepsis include a low platelet count, and elevated INR, creatinine, and bilirubin.***Chemistry:**Lactate Level as soon as diagnosis of sepsis is suspected If initial lactate level is 2 mmol/L or greater, repeat Lactate level within 6 hours of sepsis presentationCMP now□ CMP daily□ BMP Daily□LFT \_\_\_ Now \_\_\_ Daily□ Lipase \_\_\_ Now \_\_\_ Daily□ Amylase \_\_\_ Now \_\_\_ Daily□ Ionized calcium**Blood Gases:**Arterial Blood Gas (if not done in ER), NOW□ Arterial Blood Gas daily**Blood Bank:**□ Type and Screen□ Packed Red Blood Cells \_\_\_ units**Coagulation:**□ D-Dimer |
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|  |  | *Laboratory (continued):*PTT Now□ PTT dailyPT/INR Now□ PT/INR daily**Hematology:**CBC with differential Now□ CBC with differential daily**Immunoassays:**□ Clostridium difficile toxin A and B genes by PCR (stool)□ Streptococcus pneumonia antigen (urine)**Inflammatory Markers:**□ C-reactive protein□ Sed rate |
|  |  |  **Microbiology**:Urine culture Blood cultures (2 sets drawn from 2 different sites before any antibiotics are given)Sputum cultures□ Influenza A/B swab**Urinalysis:**□ Urinalysis today |
|  |  | 1. **Imaging:**

Chest X-Ray 2 views□ Portable Chest X-Ray now□ Routine upright X-Ray of the abdomen today□ 12-lead ECG \_\_\_ Now \_\_\_ daily□ ECHO□ Abdominal ultrasound today□ Chest ultrasound today□ Abdominal/Pelvic CT today□ Chest CT□ Head CT |
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|  |  | 1. **Consultations:**

□ Cardiology□ Case Management□ Dietitian□ Endocrinology□ Gastroenterology□ General Surgery□ Nephrology□ Neurology□ Pulmonology□ Physical Therapy re: Evaluate and treat□ Occupational Therapy re: Evaluate and treat□ Social Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(reason)□ Hospital Chaplain |
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