

(place patient label here)

Patient Name: _____



Order Set Directions:

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Diagnosis: _____ Allergies: _____

ICU Sepsis

Version 5 1/11/17

- This order set must be used with an admission order set if patient not already admitted.

Nursing Orders

- Verify that cultures have been obtained before starting antibiotics
- Glucose, blood, point-of-care measurement , every six hours
- Notify provider if blood glucose is greater than 200 mg/dL x 2 for Dynamic Insulin Drip orders
- Initiate Hypoglycemia Protocol if Capillary Blood Glucose is less than or equal to 70 mg/dL and Notify Provider
- Central venous pressure (CVP) and/or ScvO2 monitoring: after central line placement verified by physician

Respiratory

Ventilator Settings:

- For ventilator orders- Select ICU Ventilator Bundle order set
 - Ventilator Settings: Mode: _____; Rate: _____ bpm; volume: _____ mL; Pressure _____ cm H2O; PEEP: _____ cm H2O; PS _____ cm H2O; I:E Ratio _____; HIGH PEEP: _____ cm H2O; LOW PEEP: _____ cm H2O; FiO2: _____ %

Diet

- NPO Other: _____

IV/ Line Placement

- Arterial IV insert/maintain
- Central Venous Catheter Maintain

IV Fluids - Generic Volume Bolus

IV Fluid-Bolus

- Fluid: Sodium Chloride 0.9%
 - Additive: _____
 - Volume to Infuse: 30 mL/kg = _____ mL
 - Rate: _____
 - Duration (If rate not selected): _____

IV Fluids - Maintenance Specific Fluid

Sodium Chloride 0.9% IV

- 150 milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.9% Sodium Chloride IV

- _____ milliliter/hour continuous intravenous infusion

Medications

- Pharmacy to renal dose all medications and adjust kinetics

Analgesics

acetaminophen (TYLENOL)

- 650 milligram orally every 6 hours as needed for fever greater than 101 F (38.3 C)
- 650 milligram by feeding tube every 6 hours as needed for fever greater than 101 F (38.3 C)
- 650 milligram suppository rectally every 6 hours as needed for fever greater than 101 F (38.3 C)

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Bronchodilators

Nebulized Agents

- albuterol 2.5 mg/3 mL (0.083 %) solution for nebulization (VENTOLIN)
 - 2.5 milligram by nebulizer every 4 hours
 - 2.5 milligram by nebulizer every 2 hours as needed for respiratory distress
- albuterol-ipratropium 2.5 mg-0.5 mg/3 mL soln for inhalation (DUONEB)
 - 3 milliliter by nebulizer every 4 hours
 - 3 milliliter by nebulizer every 4 hours, while awake

Inhalation Agents

- albuterol 90 microgram/inhalation aerosol inhaler
 - 6 puff inhaled every 4 hours
 - 6 puff inhaled every 2 hours as needed for respiratory distress
- ipratropium 17 mcg/actuation aerosol inhaler (ATROVENT)
 - 6 puff inhaled every 4 hours
 - 6 puff inhaled every 2 hours as needed for respiratory distress

Corticosteroids: Systemic

- hydrocortisone (SOLU-CORTEF)
 - 50 milligram intravenously every 6 hours

Vasoactive Agents

- norepinephrine bitartrate in D5W 4 mg/250 mL IV (LEVOPHED)
 - 1-30 microgram/minute continuous intravenous infusion : titrate to keep systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg
- EPINEPHrine HCl in 0.9 % NaCl 4 mg/250 mL (16 mcg/mL) IV
 - 0.01-0.15 microgram/kilogram per minute continuous infusion : titrate to keep systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg
- DOBUTamine (DOBUTREX) [500 milligram/ 250 milliliter D5W]
 - 2.5-10 microgram/kilogram per minute continuous intravenous infusion : titrate to keep SvO greater than 70%, maintaining systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg and Heart Rate less than 140 beats per minute
- vasopressin [100 unit/250 milliliter NS]
 - 0.01-0.04 unit/minute continuous intravenous infusion : titrate to keep SBP greater than 90mmHg and MAP greater than or equal to 65mmHg

Insulin Correction Level

insulin lispro (HUMALOG) subcutaneous correction level:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Low Dose Correction: | <input type="checkbox"/> Medium Dose Correction: | <input type="checkbox"/> High Dose Correction: | <input type="checkbox"/> Custom Dose Correction: |
| 141 - 180 mg/dL 0 unit; | 141 - 180 mg/dL 2 unit; | 141 - 180 mg/dL 4 units; | 140 -180 mg/dL ___ units; |
| 181- 220 mg/dL 2 units; | 181- 220 mg/dL 4 units; | 181- 220 mg/dL 7 units; | 181 - 220 mg/dL ___ units; |
| 221 - 260 mg/dL 3 units; | 221 - 260 mg/dL 6 units; | 221 - 260 mg/dL 10 units; | 221 - 260 mg/dL ___ units; |
| 261 - 300 mg/dL 5 units; | 261 - 300 mg/dL 8 units; | 261 - 300 mg/dL 13 units; | 261- 300 mg/dL ___ units; |
| 301-350 mg/dL 7 units; | 301-350 mg/dL 10 units; | 301-350 mg/dL 15 units; | 301 - 350 mg/dL ___ units; |
| greater than 350 mg/dL- | greater than 350 mg/dL- | greater than 350 mg/dL- | greater than 350 mg/dL- |
| Call Provider | Call Provider | Call Provider | Call Provider |

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Insulins: Continuous IV Infusions

- insulin regular human : Initiate insulin drip protocol- Initiate if capillary blood glucose is greater than 200 mg/dL x 2

Antibacterial Agents:

- All empiric antibiotics should be re-addressed after final culture results are reviewed

Pneumonia-Community-acquired

- No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin:**
 - cefTRIAxone (ROCEPHIN) 2 gram intravenously every 24 hours
 - azithromycin (ZITHROMAX) 500 milligram intravenously every 24 hours
- Cephalosporin Allergy or Anaphylaxis to Penicillin:**
 - tobramycin 5 milligram/kilogram intravenously once then consult pharmacy to dose
 - levofloxacin (LEVAQUIN) 750 milligram intravenously every 24 hours

Pneumonia- Nosocomial (recent hospitalization or ECF resident)

- No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin:**
 - vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
 - ciprofloxacin 400 milligram intravenously 2 times daily
 - cefepime (MAXAPIME) 2 gram intravenously every 8 hours
- Cephalosporin Allergy or Anaphylaxis to Penicillin:**
 - vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
 - ciprofloxacin 400 milligram intravenously 2 times daily
 - tobramycin 5 milligram/kilogram intravenously once then consult pharmacy to dose

UTI with Sepsis (not simple cystitis or uncomplicated pyelonephritis)

- No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin:**
 - vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
 - cefepime (MAXAPIME) 2 gram intravenously every 12 hours
 - fluconazole (DIFLUCAN) 400 milligram intravenously once followed by 200 milligram intravenously every 24 hours
- Cephalosporin Allergy or Anaphylaxis to Penicillin:**
 - vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
 - tobramycin 5 milligram/kilogram intravenously once then consult pharmacy to dose
 - fluconazole (DIFLUCAN) 400 milligram intravenously once followed by 200 milligram intravenously every 24 hours

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Severe Intra-abdominal Infection

No Penicillin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
piperacillin-tazobactam (ZOSYN) 4.5 gram intravenously every 6 hours
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours

Penicillin Allergy and No Cephalosporin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours
metroNIDAZOLE (FLAGYL) 500 milligram intravenously every 6 hours
cefepime (MAXAPIME) 2 gram intravenously every 8 hours

Penicillin Allergy AND Cephalosporin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours
metroNIDAZOLE (FLAGYL) 500 milligram intravenously every 6 hours
tobramycin 5 milligram/kilogram intravenously once then consult pharmacy to dose

Sepsis, Source Unknown

No Penicillin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
piperacillin-tazobactam (ZOSYN) 4.5 gram intravenously every 6 hours
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours

Penicillin Allergy and No Cephalosporin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours
metroNIDAZOLE (FLAGYL) 500 milligram intravenously every 6 hours
cefepime (MAXAPIME) 2 gram intravenously every 8 hours

Penicillin Allergy AND Cephalosporin Allergy:

vancomycin 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose
micafungin (MYCAMINE) 100 milligram intravenously every 24 hours
tobramycin 5 milligram/kilogram intravenously once then consult pharmacy to dose

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Laboratory

- Do not repeat labs done in ER

Admission labs or labs to be obtained now:

- BLOOD CULTURE, from two different sites five minutes apart
- UA WITH MICROSCOPY
- CULTURE, URINE
- CULTURE, SPUTUM AND GRAM ST
- DIC SCREEN
- CULTURE, WOUND AND GRAM STAIN [RB]
- CBC/AUTO DIFF
- COMPREHENSIVE METABOLIC PANEL
- MAGNESIUM LEVEL, PLASMA
- PHOSPHORUS LEVEL, PLASMA
- TROPONIN I
- PROCALCITONIN
- LACTIC ACID, PLASMA every 2 hours x 3
- Blood gas, arterial

Blood gas, venous

- stat on arrival from central line and repeat every 6 hours x 2 IF no ScvO2 monitoring
- URINE DRUG SCREEN

Morning Labs:

- CBC/AUTO DIFF
- COMPREHENSIVE METABOLIC PANEL
- MAGNESIUM LEVEL, PLASMA
- PHOSPHORUS LEVEL, PLASMA
- PROCALCITONIN

Blood Bank

- Select the Transfusion Order set to order blood products

Radiology and Diagnostic Tests

XR Chest Single , portable,

- now if not done in last 6 hours. Reason for exam: _____
- routine in AM, Reason for exam: _____

ECG

- routine Reason for exam: _____

ECHO, Transthoracic Complete

- stat ICD 9 Indications: _____ Contrast? [] Yes [] No Agitated
Saline (Bubble Study) [] Yes [] No Additional Instructions: _____
- routine ICD 9 Indications: _____ Contrast? [] Yes [] No Agitated
Saline (Bubble Study) [] Yes [] No Additional Instructions: _____

CT scan

- with contrast
- without contrast
- Location: _____ Reason for exam: _____

Ultrasound

- routine Location: _____ Reason for exam: _____

Provider Signature: _____ Date: _____ Time: _____