(place patient label here)

Patient Name: ____________________

Order Set Directions:
- (√) Check orders to activate; Orders with pre-checked box will be followed unless lined out.
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Diagnosis: _________________________

Allergies with reaction type: _________________________

Orthopedic Admission Hip Fracture

Patient Placement

Patient Status
- If the physician cannot anticipate that the duration of episode of care for the patient will cross two midnights, the patient should continue to be treated as an outpatient (observation services) and should be admitted if or when additional information suggests or the physician anticipates that the duration of the episode of care will cross a second midnight.
  - Admit to inpatient: **I certify that:
    - Inpatient services are reasonable and necessary and ordered in accordance with Medicare regulations.
    - Services ordered are appropriate for the inpatient setting.
    - It is anticipated that the medically necessary care of the patient will cross at least 2 midnights. The diagnosis included in this order is the reason for inpatient services and is outlined further in the history and physical and subsequent progress notes.
    - The need for post hospital care will be determined based upon the patient's evolving clinical condition and needs.

Diagnosis: _________________________
- Observation services (Condition can be evaluated/treated/improved within 2 midnights or additional time is needed to determine if inpatient admission is medically necessary)
- Attending Provider: ________________________________

Preferred Location/Unit
- (√) Ortho/Neuro
- ( ) PCU
- ( ) ICU

Code Status:
- ( ) Full Code
- ( ) DNR

Limited DNR Status
- ( ) No intubation, mechanical ventilation
- ( ) No chest compressions
- ( ) No emergency medications or fluid
- ( ) No defibrillation, cardioversion
- ( ) No _________________________

Activity
- (√) Bed rest

Equipment and Activity Aids
- ( ) Apply traction
  - Location: _________________________
  - Type: _________________________
  - Pounds of Traction: _________________________
  - Additional Instructions: _________________________
- (√) Adaptive Equipment per PT
- (√) Adaptive Equipment per OT

Initials________________
Nursing Orders
☐ Vital signs per unit standard
☐ Vital signs non unit standard
☐ Point of Care Capillary Blood Glucose QID, before meals and at bedtime
☐ Intake and output per unit standard
☐ Initiate MRSA/MSSA Testing and Treatment Protocol
☐ Apply ice pack to affected extremity
☐ Elevate Affected Extremity
☐ Incentive spirometry every hour while awake
☐ Confusion Assessment Method (CAM) once per shift
☐ IF Confusion Assessment Method (CAM) is positive for delirium, notify provider

Respiratory
☐ Oxygen Delivery RN/RT to Determine Titrate to maintain Oxygen saturation greater than 90%

Diet
☐ NPO (diet) [ ] Enter Time: _____ [x ] Midnight [ ] Now
☐ NPO Modifications: [ ] Except Meds [ ] Strict [ ] With Ice Chips [ ] With Sips
☐ Clear Liquid
☐ Regular
☐ Additional Instructions: Carb Controlled if patient has history of diabetes

IV Placement
☐ Peripheral IV insert/maintain

IV Fluids - Maintenance Specific Fluid
☐ Sodium Chloride 0.9% IV
☐ 125 milliliter/hour continuous intravenous infusion
☐ Dextrose 5% and 0.9% Sodium Chloride IV
☐ 125 milliliter/hour continuous intravenous infusion

Medications
Analgesics
acetaminophen (TYLENOL)
☐ 650 milligram tablet orally every 4 hours as needed for mild-to-moderate pain
☐ 650 milligram suppository rectally every 4 hours as needed for mild-to-moderate pain
HYDROCodone-acetaminophen 5 mg-325 mg tab (NORCO)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain
oxyCODONE-acetaminophen 5 mg-325 mg tab (PERCOCET)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

Initials__________
Patient Name: ____________________________

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**Analgesics (PCA): Select one**

- HYDROMorphone normal saline 0.2 mg/mL (DILAUDID - PCA)
  - [ ] Standard PCA
  - Demand dose: 0.2 milligram;
  - Demand dose lock out: 8 minutes;
  - Maximum doses/hour: 7 doses/hour
  - **D/C POST OP DAY 1**
  - **IF signs/symptoms of opioid induced respiratory depression: STOP PCA or IV Opiate infusions if applicable AND Initiate Respiratory Depression Protocol AND Notify Provider**

- Morphine in normal saline 1 mg/mL (PCA)
  - [ ] Standard PCA
  - Demand dose: 1 milligram;
  - Demand dose lock out: 8 minutes;
  - MAX doses/hour: 7 doses/hour
  - **D/C POST OP DAY 1**
  - **IF signs/symptoms of opioid induced respiratory depression: STOP PCA or IV Opiate infusions if applicable AND Initiate Respiratory Depression Protocol AND Notify Provider**

- Fentanyl in normal saline 10 micrograms/mL (PCA)
  - [ ] Standard PCA
  - Demand dose: 10 micrograms;
  - Demand dose lock out: 8 minutes;
  - Maximum doses/hour: 7 doses/hour
  - **D/C POST OP DAY 1**
  - **IF signs/symptoms of opioid induced respiratory depression: STOP PCA or IV Opiate infusions if applicable AND Initiate Respiratory Depression Protocol AND Notify Provider**

**Antiemetics**

- Metoclopramide (REGLAN)
  - [ ] 5 milligram orally every 4 hours as needed for nausea/vomiting
  - [ ] 5 milligram intravenously every 4 hours as needed for nausea/vomiting

- Ondansetron (ZOFRAN)
  - [ ] 4 milligram intravenously every 4 hours as needed for nausea/vomiting

**Miscellaneous**

- Alum-mag hydroxide-simeth (MINTOX)
  - [ ] 15-30 milliliter orally every 4 hours as needed for dyspepsia

- Docusate sodium (COLACE)
  - [ ] 100 milligram orally 2 times a day. Hold for loose stools

**Laboratory**

- [ ] CBC/Auto diff
- [ ] Comprehensive Metabolic Panel
- [ ] Basic Metabolic Panel
- [ ] PT (Prothrombin time & INR)
- [ ] PTT
- [ ] Urinalysis, microscopic, culture if indicated
- [ ] Vitamin D (25-Hydroxy) level (hip fracture fragility test)
- [ ] TSH, with reflex to FT4 if indicated (if on thyroid replacement)

Initials___________
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Consult Provider
● Provider to provider notification preferred
   ☑ Consult Orthopedics regarding hip fracture
     Does nursing need to contact consulted provider? [ ] Yes [ ] No
   ☐ Consult Physiatrist. Reason for consult: Recommended Disposition and/or Rehabilitation.

Consult Department
   ☑ Consult Care Coordination. Reason for consult: Discharge Planning
   ☐ Consult Wound Nurse. Reason for consult: ________________________
     Initiate Wound Care Protocol [ ] Yes [ ] No
   ☐ Consult Palliative Care
**VTE Prophylaxis**

**Step 1: VTE Risk Assessment: SELECT ONE RISK CATEGORY**

- **LOW RISK - FEW PATIENTS FALL IN THIS CATEGORY** (Includes ambulatory patients WITHOUT additional VTE risk factors [see Appendix 1 for risk factors]) No specific measure required, early ambulation
  - **Order for all LOW risk patients IF not already ordered.**
  - Ambulate 3 times a day

- **MODERATE RISK - ANY PATIENT NOT IN LOW RISK OR HIGH RISK CATEGORY - MOST PATIENTS FALL IN THIS CATEGORY** (Patients with one or more VTE risk factors)

- **HIGH RISK - ANY PATIENT NOT IN LOW OR MODERATE RISK CATEGORY** (Includes: Elective major lower extremity arthroplasty, hip, pelvic or surgery, lower extremity fracture, acute spinal cord injury with paresis, multiple major trauma, abdominal or pelvic surgery for cancer)

**Step 2: Order Prophylaxis**

- Prophylaxis already addressed post-operatively- See post-op orders

  - **Pharmacological VTE Prophylaxis**
    - **Order for MODERATE and HIGH risk patients unless contraindicated**

- No pharmacological prophylaxis due to the following contraindications: SELECT ALL THAT APPLY

<table>
<thead>
<tr>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute</td>
</tr>
<tr>
<td>Active hemorrhage or high risk for hemorrhage</td>
</tr>
<tr>
<td>Severe trauma to head or spinal cord WITH hemorrhage in last 4 wks</td>
</tr>
<tr>
<td>Relative</td>
</tr>
<tr>
<td>Craniotomy in last 2 weeks</td>
</tr>
<tr>
<td>Intracranial hemorrhage in 12 mos.</td>
</tr>
<tr>
<td>Intraocular surgery in last 2 wks</td>
</tr>
<tr>
<td>GI, GU hemorrhage in last 30 days</td>
</tr>
<tr>
<td>Thrombocytopenia (&lt; 50,000)</td>
</tr>
<tr>
<td>Coagulopathy (PT &gt; 18 sec)</td>
</tr>
<tr>
<td>Relative</td>
</tr>
<tr>
<td>Active intracranial lesions/ neoplasms</td>
</tr>
<tr>
<td>Hypertensive emergency</td>
</tr>
<tr>
<td>Post-op bleeding concerns</td>
</tr>
<tr>
<td>Scheduled to return to OR in the next 24 hrs</td>
</tr>
<tr>
<td>Epidural catheters or spinal block</td>
</tr>
<tr>
<td>End stage liver disease</td>
</tr>
</tbody>
</table>

**OTHER:**

- **Other Medications:**
  - enoxaparin (LOVENOX)
    - 40 milligram subcutaneously once a day
    - 30 milligram subcutaneously once a day for impaired renal function- GFR less than 30 mL/min
  - heparin
    - 5,000 unit subcutaneously every 12 hours
    - 5,000 unit subcutaneously every 8 hours
  - Select fondaparinux (ARIXTRA) ONLY IF suspected or known history of immune-mediated HIT OR allergy to enoxaparin (LOVENOX)
  - fondaparinux (ARIXTRA)
    - 2.5 milligram subcutaneously once a day DO NOT USE if GFR less than 30mL/min
  - Other Medication: __________________________________________________________

- **Laboratory**
  - CBC without differential every 3 days IF pharmacological prophylaxis is ordered

  - **Mechanical VTE Prophylaxis**
    - **Order for HIGH risk patients and MODERATE risk patients without pharmacological prophylaxis**

- No mechanical prophylaxis due to the following contraindications: SELECT ALL THAT APPLY

<table>
<thead>
<tr>
<th>Mechanical Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral lower extremity amputee</td>
</tr>
<tr>
<td>Bilateral lower extremity trauma</td>
</tr>
<tr>
<td>Other:________________________</td>
</tr>
</tbody>
</table>

- Intermittent pneumatic compression
  - Apply anti-embolic stockings (graduated)
  - Sequential compression device (SCD)
    - knee high
  - Arterial venous impulses (AVI)
    - thigh high

Provider Signature: ___________________ Date: __________ Time: ________