(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

Order Set Directions:
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Diagnosis: _____

Allergies with reaction type:_____

Orthopedic Admission

Version 3 11/01/17

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.

☐ Observation services
Observation reason:
Patient may require further evaluation to determine whether an inpatient admission is medically necessary [ ] Yes [ ] No
Patient's symptoms are anticipated to improve quickly with medical management [ ] Yes [ ] No

☐ Attending Provider: _____

Preferred Location/Unit

☑ Ortho/Neuro
☐ General Medical
☐ 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 _____

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Activity
- ☐ Up with Assistance as needed
- ☐ May ambulate
- ☐ Bed rest
- ☐ Upper Ext Weight-bearing Status
  Right: [ ] As Tolerated [ ] Non Weight Bearing [ ] Partial
  Left: [ ] As Tolerated [ ] Non Weight Bearing [ ] Partial
- ☐ Range of Motion Restrictions
  Location: _____
  Type: [ ] Active [ ] Passive [ ] As Tolerated
  Elevation Degrees: ____
  Internal Rotation Degrees: _____
  External Rotation Degrees: _____
- ☐ Lower Ext Weight-bearing Status
  Left Leg: [ ] Non Weight Bearing [ ] Partial [ ] Toe Touch [ ] Heel Touch [ ] As tolerated
  Right Leg: [ ] Non Weight Bearing [ ] Partial [ ] Toe Touch [ ] Heel Touch [ ] As tolerated

Equipment and Activity Aids
- ☐ Apply traction
  Location: _____
  Type: _____
  Additional Instructions: _____
- ☐ Adaptive Equipment
  Type: [ ] Cane [ ] Crutches [ ] Front Wheeled Walker [ ] Wheelchair [ ] Reacher [ ] Sock Donner [ ] Other _____
  Additional Instructions: _____

Nursing Orders
- ☑ Vital signs per unit standard
- ☐ Vital signs non unit standard _____

Point of Care Capillary Blood Glucose
- ☐ 4 times a day, before meals and at bedtime
- ☑ Intake and output per unit standard
- ☑ Initiate MRSA Testing and Treatment Protocol
- ☐ Apply ice pack to affected extremity
- ☐ Elevate Affected Extremity
- ☑ Initiate Carrier Fluid Protocol IF NO Maintenance IV currently running

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

Diet
- ☐ Regular Diet
- ☐ Heart Healthy Diet
- ☐ Controlled Carbohydrate Diet
- ☐ Full Liquid Diet
- ☐ Clear Liquid Diet
- ☐ NPO (diet) [ ] Enter Time: _____ [ ] Midnight [ ] Now

NPO Modifications: [ ] Except Meds [ ] Strict [ ] With Ice Chips [ ] With Sips

Initials_____

(place patient label here)

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BENEFIS HEALTH SYSTEM
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PROVIDER ORDERS

IV Placement

☐ Peripheral IV insert/maintain

IV Fluids - Maintenance Specific Fluid

Sodium Chloride 0.9% IV
- ☐ 125 milliliter/hour continuous intravenous infusion

Lactated Ringers IV
- ☐ 125 milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.45% Sodium Chloride IV
- ☐ 125 milliliter/hour continuous intravenous infusion

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

Sodium Chloride 0.9% with Potassium Chloride 20 mEq/L IV (PREMIX)
- ☐ 125 milliliter/hour continuous intravenous infusion

D5-0.45% Sodium Chloride with Potassium Chloride 20 mEq/L IV (PREMIX)
- ☐ 125 milliliter/hour continuous intravenous infusion

IV Fluids - Maintenance Generic Fluid

- Select this fluid for IV solution not listed above

IV Fluid-Maintenance
- ☐ Fluid: _____ Additive: _____

Rate: _____Duration (If rate not selected):_____

Medications

Analgesics

acetaminophen 325 mg tablet (TYLENOL)
- ☑ 650 milligram orally every 4 hours as needed for mild-to-moderate pain or fever greater than 100.5 F

acetaminophen (TYLENOL)
- ☑ 650 milligram suppository rectally every 4 hours as needed for mild-to-moderate pain or fever greater than 100.5 F

oxyCODONE-acetaminophen 5 mg-325 mg tab (PERCOCET)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

oxyCODONE-acetaminophen 7.5 mg-325 mg tab (PERCOCET)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

oxyCODONE-acetaminophen 10 mg-325 mg tab (PERCOCET)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

HYDROcodone-acetaminophen 5 mg-325 mg tab (NORCO)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

HYDROcodone-acetaminophen 7.5 mg-325 mg tab (NORCO)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

HYDROcodone-acetaminophen 10 mg-325 mg tab (NORCO)
- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

oxyCODONE 5 mg tablet
- ☐ 1-3 tablet orally every 3 hours as needed for breakthrough pain

morphine

Initials_____

☐ 2 milligram intravenously every 4 hours as needed for severe pain, break through pain

Analgesics (PCA): Select one

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

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

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)

☐ 10 milligram orally every 4 hours as needed for nausea/vomiting
☐ 10 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 (PROTIME AND INR)
☐ PTT

Initials_____

(place patient label here)

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BENEFIS HEALTH SYSTEM
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HOSPITALS

PROVIDER ORDERS

☐ UAMIC/ CULT IF INDICATIED

Consult Provider

- Provider to provider notification preferred.
  - ☐ Consult Hospitalist
  - ☐ Consult other provider _____ regarding _____ Does nursing need to contact consulted provider? [ ] Yes [ ] No

Consult Department

- ☐ Consult Care Coordination Reason for consult: _____
- ☐ Consult Wound Care Reason for consult: _____
  Initiate Wound Care Protocol [ ] Yes [ ] No

Initials_____

(place patient label here)

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PROVIDER ORDERS

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

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

Mechanical Contraindications
☐ Bilateral lower extremity amputee ☐ Bilateral lower extremity trauma ☐ Other:_____

Intermittent pneumatic compression
- ☐ Sequential compression device (SCD)
- ☐ Arterial venous impulses (AVI)

Apply anti-embolic stockings (graduated)
- ☐ knee high
- ☐ thigh high

Initi

(place patient label here)

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PROVIDER ORDERS

Surgical Pre-op Orders

☐ Order for Surgery Specific Surgery:

_____

_____

_____

Date of Surgery: _____

Obtain the Written Authorization for Ordered Surgery

Nursing Orders

☐ Initiate pre operative anesthesia protocol
☐ Inform Anesthesia: NO ketaraloc tromethamine (TORADOL)
☐ Foley Catheter place in OR

- For knee procedures only SELECT:
  ☐ Apply thigh high compression stockings (to non-operative leg only if lower extremity surgery)
- For all other procedures only SELECT:
  ☐ Apply knee high compression stockings (to non-operative leg only if lower extremity surgery)
  ☐ Apply Sequential Compression Device -place in OR
  ☐ Apply Arterial Venous Impulses -place in OR
  ☐ Surgical Site Scrub with _____
  ☐ Pre-op shower/CHG Wipes with _____ night before surgery and morning of surgery
  ☐ Surgical site hair removal use electric clippers

Perioperative Antibacterial Prophylaxis

☐ No antibiotic prophylaxis indicated
☐ Initiate GROUP 1 Antibacterial Prophylaxis Protocol (Nursing to place Group 1 antibiotic orders using the Group 1 ABX Protocol Orders set)
☐ Initiate GROUP 2 Antibacterial Prophylaxis Protocol (Nursing to place Group 2 antibiotic orders using the Group 1 ABX Protocol Orders set)

Pre-op Laboratory and Diagnostic Tests

- For women of childbearing age (10-50) except those with hysterectomy or tubal ligation SELECT:
  ☐ PREGNANCY TEST, SERUM
  ☐ Type and screen
  ☐ Packed Cell ___ unit(s) red blood cells (RBC)

XR Chest single

☐ routine , Reason for exam: anesthesia guidelines

ECG (Electrocardiogram)

☐ routine Reason for exam: anesthesia guidelines

Provider Signature:_____Date:_____Time:_____