

# COPD Exacerbation Admit Orders

**Check Boxes to Activate.**

<p><b>ADMISSION INFORMATION</b></p> <p>Ht: _____</p> <p>Wt: _____</p>	<p>Admit to: <input type="checkbox"/> <b>HOSPITALIST SERVICE</b> and/or <input type="checkbox"/> Dr. _____</p> <p><input type="checkbox"/> Med/Surg <input type="checkbox"/> ICU (see Critical Care Auth. Sheet) <input type="checkbox"/> Tele (see Tele Standing Orders)</p> <p>Secondary diagnoses: _____</p> <p>Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____</p> <p>Code Status: (See Goldenrod)</p> <p>Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown</p>
<p><b>REFERRALS</b></p>	<p><input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Dysphagia <input type="checkbox"/> Wound/Ostomy Care RN</p> <p><input type="checkbox"/> Financial Services <input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____</p> <p>Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture</p> <p><input type="checkbox"/> Music Care <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Osteopathy</p>
<p><b>NURSING CARE</b></p>	<p>VS: <input type="checkbox"/> Per unit Protocol <input type="checkbox"/> Every _____ hours</p> <p>I&amp;O daily <input type="checkbox"/> Weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion</p> <p><input type="checkbox"/> Notify physician if: HR &lt;60 or &gt;120 ■ SBP &lt;80 or &gt;160 ■ DBP &gt;100 ■ RR &lt;8 ■ Temp &gt;101.5</p> <p>■ SpO2 &lt;90% ■ Urine Output &lt;20 ml/hr X 2 hours</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: ■ HR &lt; _____ or &gt; _____ ■ SBP &lt; _____ or &gt; _____ ■ DBP &lt; _____ or &gt; _____</p> <p>■ RR &lt; _____ or &gt; _____ ■ Temp &gt; _____ ■ SpO2 &lt; _____ % ■ Urine Output &lt; _____ ml/hr</p> <p><input type="checkbox"/> Bed rest <input type="checkbox"/> BSC <input type="checkbox"/> OOB to chair at least _____ daily <input type="checkbox"/> Amb as tol. <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Smoking cessation education</p>
<p><b>LAB</b></p>	<p>On admit (if not done in ED): <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> CPK <input type="checkbox"/> Myoglobin <input type="checkbox"/> Troponin <input type="checkbox"/> PT/INR <input type="checkbox"/> PTT</p> <p><input type="checkbox"/> D-Dimer <input type="checkbox"/> ABG <input type="checkbox"/> B-type Natriuretic Peptid <input type="checkbox"/> Other: _____</p> <p>AM Labs: _____ Daily Labs: _____</p>
<p><b>X-RAY</b></p>	<p>CXR: <input type="checkbox"/> PA/Lat <input type="checkbox"/> Portable</p>
<p><b>DIETARY</b></p>	<p><input type="checkbox"/> Dietary Consult <input type="checkbox"/> NPO <input type="checkbox"/> Clear Liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Regular <input type="checkbox"/> _____ Gm Sodium</p> <p><input type="checkbox"/> Cardiac <input type="checkbox"/> _____ Calories ADA <input type="checkbox"/> Other: _____</p>
<p><b>RESPIRATORY CARE</b></p>	<p>SpO2: <input type="checkbox"/> Every shift <input type="checkbox"/> With room air ambulation</p> <p><input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB</p> <p><input type="checkbox"/> O<sub>2</sub> to maintain SpO<sub>2</sub> ≥ 92% or _____ %</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</p> <p><input type="checkbox"/> Tiotropium (Spiriva ) 18mcg 1 capsule by DPI daily</p> <p><input type="checkbox"/> Fucicason (Flovent) <input type="checkbox"/> 110mcg <input type="checkbox"/> 220mcg 2 puffs inhaled BID</p> <p><input type="checkbox"/> Fluticasone/salmeterol (Advair) diskus <input type="checkbox"/> 100/50 <input type="checkbox"/> 250/50 or <input type="checkbox"/> 500/50 _____ puffs <input type="checkbox"/> Daily <input type="checkbox"/> BID</p> <p><input type="checkbox"/> BIPAP: RR _____ I _____ cm E _____ cm @ _____ liter/min and initiate BIPAP protocol (<b>ICU only</b>)</p> <p><input type="checkbox"/> Vent (see Ventilator Orders) (<b>ICU only</b>)</p> <p><input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Xopenex 1.25mg by HHN _____ hours PRN SOB, wheezing, or desaturation</p> <p>OR</p> <p><input type="checkbox"/> Albuterol 90 mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) MDI 0.5mg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation</p>
<p><b>INFECTION PREVENTION</b></p>	<p><input type="checkbox"/> Isolation Precautions—for: _____</p> <p><b>MRSA LEGAL REQUIREMENTS:</b></p> <p><input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>ADMIT</u> if: Discharged from an acute care hospital within past 30 days; <b>OR</b> Transferred from a nursing facility; <b>OR</b> Admission to ICU (one screen per hospital stay).</p> <p><input type="checkbox"/> Positive MRSA History—Do not test. Start Glove Precautions.</p> <p><input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>DAY OF DISCHARGE</u> if Palm Drive LOS &gt; 10 days <b>AND</b> patient was in ICU.</p> <p><b>CULTURES:</b> <input type="checkbox"/> wound <input type="checkbox"/> aspiration closed wound <input type="checkbox"/> sputum (PNA) <input type="checkbox"/> U/A with UTI symptoms/Hx <input type="checkbox"/> Blood</p> <p><b>DIARRHEA:</b> (3 or more unformed stools in past 24 hours)—NOTIFY I.P. x4386 and send stool for C-Difficile</p> <p>Other etiologies: <input type="checkbox"/> Bacterial (stool culture) <input type="checkbox"/> Norovirus <input type="checkbox"/> Parasites x3 (O&amp;P) rate <input type="checkbox"/> Other: _____</p>

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VTE Prophylaxis	PATIENT CATEGORY / RISK FACTORS	RISK	PROPHYLAXIS METHOD
	Patient is < 40 years old & no additional risk factor (See High Risk below)	LOW	<input type="checkbox"/> No specific measures; early ambulation
	Patient 40-60 years with limited mobility and no additional risk factor (see High risk below)	MOD	<input type="checkbox"/> Sequential compression device <b>OR</b> <input type="checkbox"/> TED hose <b>OR</b> <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days <b>OR</b> <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	Patient >60 yrs or any risk factor such as: CHF, MI, resp. failure, trauma (major or lower extremity), cancer, infection, restricted mobility, ICU admit, obesity, surgery, varicose veins, prior DVT/PE, chronic lung disease, inflammatory bowel disease, smoking, HRT use, pregnancy current or recent.	HIGH	<input type="checkbox"/> Sequential compression device <b>OR</b> <input type="checkbox"/> TED hose <b>PLUS</b> <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days <b>OR</b> <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	<b>Contraindications</b> to anticoagulation therapy <ul style="list-style-type: none"> <li>• No mechanical prophylaxis due to:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> bilateral amputee</li> <li><input type="checkbox"/> lower extremity trauma</li> </ul> </li> <li>• No anticoagulation at this time due to:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> pharmacological VTE prophylaxis:                                     <ul style="list-style-type: none"> <li><input type="checkbox"/> platelet count &lt;100,000/mm</li> <li><input type="checkbox"/> on warfarin prior to admit</li> <li><input type="checkbox"/> active bleeding (GI bleed)</li> <li><input type="checkbox"/> cerebral hemorrhage</li> <li><input type="checkbox"/> CVA</li> <li><input type="checkbox"/> retroperitoneal bleeding</li> <li><input type="checkbox"/> bleeding risk</li> <li><input type="checkbox"/> HIT</li> <li><input type="checkbox"/> lumbar puncture within 24 hrs</li> <li><input type="checkbox"/> epidural cath within 24 hours</li> <li><input type="checkbox"/> hypersensitivity to Heparin or Enoxaparin.</li> <li><input type="checkbox"/> patient refusal</li> <li><input type="checkbox"/> other: _____</li> </ul> </li> </ul> </li> </ul>	<b>E X C E P T I O N</b>	<input type="checkbox"/> Sequential compression device <b>OR</b>  <input type="checkbox"/> TED hose
<b>IV</b>	<input type="checkbox"/> Saline lock <input type="checkbox"/> _____ to run @ _____ ml/hr <input type="checkbox"/> PICC consult/protocol		
<b>ANTIBIOTIC</b>	See "Empiric Antibiotic Guidelines"		
<b>STEROIDS</b>	<input type="checkbox"/> Methylprednisilone (Solumedrol) 40 mg IV every 6 hours X 24 hours then Prednisone 20 mg PO TID X 2 days then 20 mg PO BID X 2 days then 20 mg PO daily X 2 days		
<b>PEPTIC ULCER PROPHYLAXIS</b>	<input type="checkbox"/> Famotidine (Pepcid) 20 mg PO/IV BID <input type="checkbox"/> Pantoprazole (Protonix) 40mg PO/IV daily		
<b>GLYCEMIC CONTROL</b>	<input type="checkbox"/> Notify physician if AM fasting blood sugar is > 140 <input type="checkbox"/> See Sliding Scale Protocol <input type="checkbox"/> Intensive Insulin protocol ( <b>ICU only</b> )		
<b>PAIN</b>	<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO/PR every 4 hours PRN mild pain (3/10 or less), temp greater than 101°F <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 1 tab PO every 4 hours PRN mild to moderate pain (< 5/10 ) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 2 tabs PO every 4 hours PRN moderate to severe pain ( ≥ 5/10 ) <input type="checkbox"/> Morphine Sulfate _____ mg IV every 2 hours PRN pain ≥ 5/10 or NPO		
<b>NAUSEA/ VOMITING</b>	<input type="checkbox"/> Prochlorperazine (Compazine) 10 mg PO/IM every 6 hours PRN <input type="checkbox"/> Dolasetron (Anzemet) 12.5 mg IV every 6 hours PRN <input type="checkbox"/> Metoclopramide (Reglan) 10 mg IV daily <input type="checkbox"/> Ondansetron (Zofran) 4mg IV every 6 hours PRN		

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<b>BOWEL CARE</b>	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate (DSS) 250 mg PO daily MOM 30 ml PO daily PRN constipation	Bisacodyl (Dulcolax) Supp PR daily PRN constipation Fleets Enema daily PRN constipation
<b>ANXIETY</b>	<input type="checkbox"/> Lorazepam (Ativan) _____ mg IV / PO (circle one) every _____ hrs PRN anxiety OR <input type="checkbox"/> Alprazolam (Xanax) 0.25 mg PO every 6 hours PRN anxiety	
<b>SLEEP</b>	<input type="checkbox"/> Temazepam (Restoril) PO HS PRN insomnia MR X 1 in 1 hour <input type="checkbox"/> 7.5 mg (rec. for >65 yrs) <input type="checkbox"/> 15 mg (for <65 yrs) OR <input type="checkbox"/> Zolpidem (Ambien) 5 mg PO HS PRN sleep MR X 1	
<b>VACCINES</b>	Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol	
<b>OTHER</b>	<input type="checkbox"/> Montelukast (Singulair) 10mg PO daily at bedtime <input type="checkbox"/> Guaifenesin LA 1200 mg PO BID <input type="checkbox"/> Multivitamin 1 tablet PO daily <input type="checkbox"/> Lactobacillus Acidophilus (Probiotic) 1 PO BID Nicotine transdermal patch: <input type="checkbox"/> 7mg daily <input type="checkbox"/> 14mg daily <input type="checkbox"/> 21mg daily <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Transcriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_