Catholic Health System

Clinical Decision Unit Orders & Criteria

Approved by Clinical Standards Committee 5/7/2019 – Version 1.0

Revisions:
Version 1.1: 5/9/2019 – Input from Dr. Stehlik
Version 1.2: 5/10/2019 – Input from Richard Geisler (Pharmacy)
Version 1.3: 5/14/2019 – Input from Dr. Shiley
Version 1.4: 5/17/2019 – Input from Dr. Stehlik
Version 1.5: 5/23/2019 – Input from Drs. Shiley & Raab
Version 1.6: 5/30/2019 – Input from COE, purpose
Version 1.7 6/11/2019 – Input from CDI, CM, COE – reference InterQual
Version 1.8 6/14/19 – Input from IT - replaced red lined order sets with updated versions

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Purpose

In order to address the top 12 most prevalence conditions for which patients are admitted to CHS under Observation status, the following document has been created to standardize care, reduce clinical practice variation, and produce the optimal outcome for patients.

The forgoing is intended to provide guidance for physicians, nurses, and other practitioners staffing Clinical Decision Units across the system, and to allow for routinely high quality of care following evidence-based standards. It is expected that deviation from these Order Sets will be justified medically and well documented.

Chart 1 displays by percentage of patients, the top diagnosis makeup of the observation population for CHS.

Chart 2 displays the percentage of patients that convert from observation status to inpatient status by diagnosis.

Chart 3 lists the top diagnosis for observation patients by site.

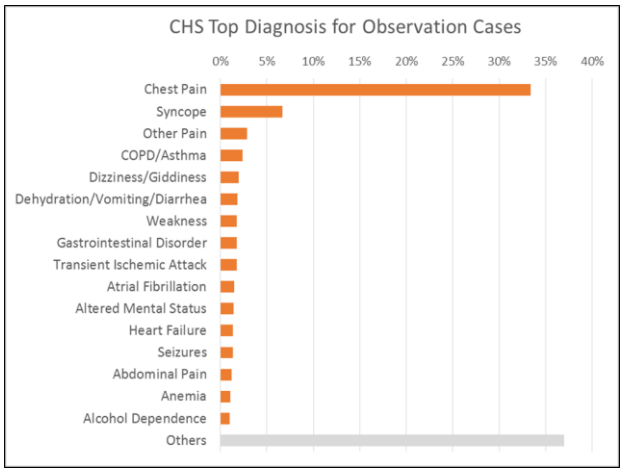

Chart 1

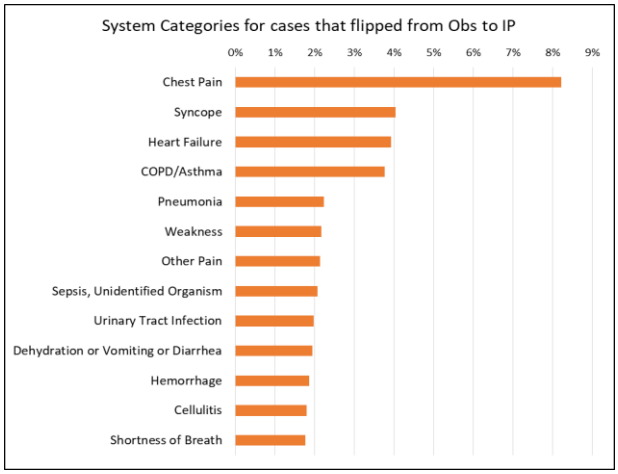

Chart 2

BMH		KMH		SCH		SJH		MSM	
Chest Pain	38%	Chest Pain	34%	Chest Pain	34%	Chest Pain	34%	Chest Pain	28%
Syncope	8%	Alcohol Dependence	6%	Syncope	7%	Syncope	8%	Syncope	7%
Other Pain	3%	Syncope	5%	Other Pain	4%	Other Pain	4%	Transient Ischemic Attack	6%
Weakness	2%	Other Pain	3%	Pretem Labor Without Delivery, 3rd Tri	3%	Anemia	3%	Dizziness and Giddiness	3%
Dizziness and Giddiness	2%	Other Malaise	3%	Dehydration or Vomiting or Diarrhea	2%	Gastrointestinal Disorder	2%	Gastrointestinal Disorder	3%
Altered Mental Status	2%	Dehydration or Vomiting or Dia	3%	Heart Failure	2%	Dizziness and Giddiness	2%	Other Pain	2%
Seizures	2%	Transient Ischemic Attack	2%	Gastrointestinal Disorder	2%	Dehydration or Vomiting or Diar	2%	Weakness	2%
Abdominal Pain	2%	Dizziness and Giddiness	2%	Atrial Fibrillation	2%	Urinary Tract Infection	2%	Heart Failure	2%
Gastrointestinal Disorder	2%	Gastrointestinal Disorder	2%	Hypertensive urgency	2%	Transient Ischemic Attack	2%	Urinary Tract Infection	2%
Dehydration or Vomiting or Dia	2%	All Others	42%	Dizziness and Giddiness	2%	All Others	43%	Atrial Fibrillation	2%
Atrial Fibrillation	2%			Anemia	2%			Seizures	2%
All Others	36%			All Others	40%			Dehydration or Vomiting or Dia	2%
								All Others	40%

Chart 3

InterQual® 2019 Physician Admission Guide

This document identifies key clinical differentiators between the Observation and Acute levels of care for clinical conditions in the Acute Adult Criteria. It is intended to serve as a guide to admitting providers to support documentation and decision making when assigning a level of care.

CHANGE HEALTHCARE

Conditions	Observation (6hrs ≥ and ≤ 48hrs)	Acute (> 48hrs)
Abdominal pain (non traumatic)	Susp/known infection OR MS changes OR GCS 9-14 OR Hx of abd surg OR vomiting after ≥ 2 antiemetic doses AND imaging AND NPO AND IVF	n/a
Acute Coronary Syndrome (ACS)	Chest pain free/controlled with medication AND SBP ≥ 90 AND troponin negative AND ECG normal/unchanged/LBBB/nondiagnostic	NSTEMI AND troponin positive OR unstable angina AND ischemic/paced ECG
Anaphylaxis/allergic reaction	Airway patent AND hemodynamically stable after epinephrine admin AND ≥ 2 epinephrine doses needed/Hx of biphasic reaction AND antihistamine/corticosteroid	Impending intubation OR mechanical ventilation OR NIPPV OR nebulizer/inhaler q 1-2 hr/continuous
Anemia, unknown etiology	Hct 18–25%/Hb 6.0–8.3 g/dL AND age < 65 OR asymptomatic OR non vit K oral anticoagulant	Hct < 18%/Hb < 6.0 g/dL OR Hct < 25%/Hb < 8.3 g/dL AND age ≥ 65 yrs OR Hct < 30%/Hb < 10.0 g/dL AND dyspnea OR orthostatic HTN OR presyncope OR syncope
Arrhythmia	Afib OR Aflutter AND onset < 48h AND resolved after ibutilide OR sustained after Rx and intervention/anti arrhythmic planned	Abnormal ECG AND syncope OR Afib or Aflutter sustained after Rx OR ICD and repetitive shocks OR supraventricular/wide complex/ventricular tachycardia OR bradycardia/junctional rhythm/AV block requiring intervention OR suspected drug toxicity requiring continuous cardiac monitoring (excludes Holter)
Asthma	Wheezing AND dyspnea OR HR > 100 OR 02 sat < 96% OR PEF/FEV 26-69% OR pulsus paradoxus > 10 mmHg OR use of accessory muscles AND failed OP Rx/failed ED Rx of ≥ 3 short-acting beta-agonist and ipratropium OR ≥ 2 short-acting beta-agonist and ipratropium if pregnant	Impending intubation OR wheezing unresolved after ED Rx AND DM with BS 300 OR pneumonia OR Hx of severe exacerbation/intubation/critical care admission OR pneumonia OR difficulty perceiving severity of asthma OR mental illness OR substance use disorder
Cellulitis	Animal/human bite of face/hand OR DM and BS > 300 mg/dL OR failed OP anti-infective OR peri-orbital OR purpura OR petechiae OR > 10% BSA OR > 50% limb or torso OR systemic symptom/finding	Immunocompromised OR located over a prosthesis/implanted device OR orbital
COPD	Dyspnea AND ≥ 3 doses short-acting beta-agonist AND 02sat 90-91% OR arterial Po2 56-60 mmHg OR Pco2 41-44 mmHg OR work of breathing	Impending intubation OR O2 ≥ 40% OR NIPPV OR mechanical ventilation OR dyspnea AND ≥ 3 doses short-acting beta-agonist AND 02sat ≤ 89% OR arterial Po2 ≤ 55 mmHg and pH > 7.45 OR Pco2 > 45 mmHg and pH < 7.35 OR use of accessory respiratory muscles or paradoxical chest wall movements or working of breathing or risk factor for respiratory failure (e.g., cor pulmonale, cancer, pneumonia, DM, home O2, Class III or IV HF).
Deep vein thrombosis (DVT)	DVT by US AND medication teaching	DVT by US AND bilateral OR creatinine clearance < 30 mL/min OR plt < 75,000/cu.mm OR susp HIT OR HIT by Hx OR risk for fall OR pregnant OR coagulopathy OR previous VTE OR active cancer OR liver disease OR recent stroke/surgery/trauma OR BMI ≥ 35kg/m2 OR immobilization OR home unsafe OR patient/caregiver unable to manage care.
Dehydration or gastroenteritis	Orthostatic hypotension OR Na > 150 mEq/L OR urine SG > 1.030 OR Cr 1.5-3 mg/dL OR BUN 25-45 mg/dL OR IV fluids OR vomiting after ≥ 2 antiemetic doses OR HR > 100 OR MS changes OR GCS 9-14	Failed Observation Rx AND vomiting OR diarrhea OR inadequate oral intake OR Na > 150 mEq/L AND advancing diet as tolerated OR antiemetic ≥ 3x/24/h OR serotonin antagonist ≥ 2x/24h OR IV fluids
Diabetic ketoacidosis (DKA)	n/a	pH ≤ 7.35 AND BS > 250 mg/dL AND ketones positive AND serum HCO3 or CO2 ≤ 18 mEq/L

Conditions	Observation (6hrs ≥ and ≤ 48hrs)	Acute (> 48hrs)
GI bleeding	Hct ≥ 30%/Hb ≥ 10 g/dL AND plt ≥ 60,000/cu.mm	Hemodynamic instability OR Hct < 30%/Hb < 10 g/dL AND plt < 60,000/cu.mm OR plt > 1,000,000/cu.mm OR PT/PTT ≥ 1.5 ULN OR INR > 2 OR HR 100 - 120 OR MS changes OR GCS 9-14 OR orthostatic HTN OR presyncope OR syncope OR non vit K anticoagulant
Heart failure (HF)	Failed OP mgt OR volume overload OR dyspnea after ≥ 1 diuretic dose and O2 sat 89-91% OR MS changes OR GCS 9-14 OR HR 100-120 OR BUN > 1.5x ULN OR Cr > 1.5x ULN OR normal LV function	Impending intubation OR NIPPV OR mechanical ventilation OR ECMO/ECLS OR VAD OR vasoactive/inotrope OR arrhythmia OR dyspnea after ≥ 1 diuretic dose and 02sat < 89% OR dyspnea and stable angina OR CKD OR COPD OR DM OR pneumonia OR mental illness OR substance use disorder OR Na < 130 mEQ/L
Hypertension (HTN)	SBP > 180 mmHg/DBP > 120 mmHg AND no evidence of end-organ damage AND history of HF/stroke/TIA/stable angina AND asymptomatic	SBP > 180 mmHg/DBP > 120 mmHg AND acute kidney injury OR HF OR aortic aneurysm OR aortic dissection OR hypertensive encephalopathy OR symptomatic
Hypertensive disorders of pregnancy	Gestation ≥ 20 weeks AND SBP 140 - 159 mmHg/DBP 90 - 109 mmHg AND FHR monitoring AND US assessment	SBP ≥ 160 mmHg/DBP ≥ 110 mmHg and anti HTN Rx OR HELLP OR preeclampsia
Migraine	Failed OP treatment OR incapacitating/intractable OR focal neurological finding AND analgesic/anti−migraine agent ≥ 2x/24h OR dihydroergotamine (DHE) and antiemetic	n/a
Nephrolithiasis (kidney stones)	Renal calculus w/o obstruction by imaging AND analgesic ≥ 2 doses AND IVF	Obstruction by imaging AND nephrostomy planned OR urinary catheterization necessary and Cr > 1.8 mg/Dl
Hypoglycemia	BS < 70 mg/L AND 50% glucose bolus x2 AND monitoring 4x/24h OR caregiver unavailable and ≤ 12h since hypoglycemia corrected	BS < 70 mg/L AND obtundation OR coma OR seizure OR stupor OR GCS ≤ 8
Pneumonia	Confirmed by imaging AND O2 sat 89−91% AND one CURB-65 criterion (confusion or BUN > 19.6 mg/dL or RR ≥ 30/min or age ≥ 65) OR failed outpatient Rx	Impending intubation OR NIPPV OR mechanical ventilation OR ECMO/ECLS OR O2 ≥ 40% OR pneumonia by imaging AND O2 sat < 89% OR arterial Po2 < 56 mmHg OR Pco2 ≥ 45 mmHg and pH ≥ 7.31 OR empyema OR ≥ 2 lobes OR O2 sat 89−91% and Class III/IV COPD/HF/mental illness/substance use disorder OR two CURB-65 criteria (confusion or BUN > 19.6 mg/dL or RR ≥ 30/min or age ≥ 65) OR lung abscess OR susp/known sepsis OR necrotizing OR pregnant and T > 99.4°F
Pulmonary embolism (PE)	PE by imaging AND age ≤ 80 AND HR < 110 AND no cancer AND no chronic lung disease AND no HF AND not pregnant AND O2 sat ≥ 90% AND SBP > 100	Impending intubation OR thrombolysis planned OR O2 ≥ 40% AND O2 sat < 89% OR NIPPV OR mechanical ventilation OR PE by imaging AND abnormal biomarkers OR pregnant OR HIT OR age > 80 OR chronic lung disease OR HR > 110 OR HF/malignancy requiring Rx
Pyelonephritis/UTI	T > normal AND pain AND u/a positive AND failed OP anti-infective OR vomiting/severe pain after Rx	T > normal AND pain AND u/a positive OR MS changes OR GCS 9-14 OR immunocompromised OR age ≥ 75 OR ≥ 24 wks gestation OR urinary stent OR urinary tract obstruction
Stroke	Prior stroke with neurological deficit exacerbation	Acute ischemic OR hemorrhagic stroke
Syncope	During exertion OR palpitations prior OR aortic stenosis OR EF < 35% OR CAD OR MI w/in last 6 mos OR new systolic murmur	Long QT syndrome
TIA	Neurological deficit resolved/resolving AND carotid stenosis OR prior stroke OR suspected embolic source	Neurological deficit resolved/resolving AND aneurysm OR cardiac tumor OR cardiac mass OR crescendo TIA OR endocardial vegetation

Condition Protocols

Abdominal Pain

Stanford Health Care (Epic 2017), Rochester Regional Health (Epic 2017)

Champions: Dr. Ralabate, Dr. Camaro

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Pain and / or tenderness resolved or significantly improved
- vital signs acceptable
- No diagnosis requiring hospitalization

Admit to Acute

- Persistent vomiting
- Pain not resolving or worsening
- Unstable vital signs
- Clinical condition or positive testing that merits hospitalization
- Surgical abdomen

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Abdominal Pain Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
❑ Consults: _____
❑ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib ❑ Ambulate with assistance ❑ Bathroom privileges

DIET:
☑ Regular ❑ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ If patient unable to void in 8 hours, utilize bladder scanner to determine residual. If residual greater than 250ml call provider
☑ Record I & O every 8 hours
☑ Saline trap
❑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain O2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.

Labs: If not already done in ED.
☑ CBC with diff ☑ BMP ☑ CMP ☑ Serum Amylase ☑ Serum Magnesium ☑ Serum Lipase
☑ CBC with diff am next day
☑ CMP am next day

Diagnostics:
☑ CT Abdomen and Pelvis with contrast IV only ❑ CT of Abdomen and Pelvis without contrast
❑ Chest x-ray ❑ Abdominal x-ray
❑ Pelvic Sonogram

MEDICATIONS:
❑ Acetaminophen (Tylenol) 650 mg PO every 4 hours PRN for mild pain
❑ Oxycodone Immediate-release 5 mg PO every 3 hours PRN Moderate pain
❑ Oxycodone Immediate-release 10 mg PO every 3 hours PRN Moderate pain
❑ Tramadol (Ultram) 50 mg PO every 6 hours PRN for Moderate pain
❑ Hydromorphone (Dilaudid) 1 mg IV every 2 hours PRN Severe pain
❑ Hydromorphone (Dilaudid) 2 mg IV every 2 hours PRN Severe pain
☑ Famotidine 20 mg IV q 12 hours

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

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Asthma & COPD Exacerbation

References: Franciscan Missionaries of Our Lady Health System, Inc. (Epic 2018), Denmark Capital Region & Region Zealand (Epic 2014), Stanford Health Care (Epic 2017), Tower Health (Epic 2017)

CHS Champions: Dr. James Fitzpatrick, Dr. Norman Sfeir

Risk Scoring Tool

10	If FEV available: Severe FEV 30%-49%
20	If FEV available: Very Severe FEV less than 30%
20	If FEV not available: If severe limitation of activities by history
30	Age > 65
10	If on oral steroids
10	If on antibiotics from past week
Documented Co-morbidities:	
10	Neoplasm
10	CHF
10	Previous stroke
10	Renal failure
Physical Findings post Treatment in ED:	
20	Altered mental status
20	Respiratory rate >= 30 /min
20	Use of accessory muscles
30	Abdominal paradox
10	Poor air entry (tight)
20	Temperature < 96.8˚F (36.0C) or >= 101˚F (38.3C)
10	Pulse rate >= 120 /min
10	No improvement in peak flow
Documented Lab and Radiology:	
30	ABG-pCO2 >45 and ph <7.30
10	Leukocytosis
30	EKG Change (Ex: RV strain or New RBBB)
30	New Infiltrate on Chest X-Ray
20	PO2 < 55mmHg or SPO2 < 88% on 2L of oxygen

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

(Patient to be discharged on steroids, nebs, with follow-up and smoking cessation)

- Acceptable Vital Signs after ambulation (if able)
- Patient is at baseline with previous O2 requirements (or Pulse Ox >95% on RA if baseline unknown)
- Resolution of bronchospasm or return to baseline status

Admit to Acute

- Progressive deterioration in clinical status or Vital Signs
- Failure to resolve exacerbation within 18 hours using scoring criteria
- Hypercarbia or respiratory acidosis

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Patient Identification Information

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Allergies & Sensitivities:

☐ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

ASTHMA & COPD EXACERBATION OBSERVATION ORDER

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ☐ _____
Admitting Physician: _____
☐ Telemetry ☐ Remote Telemetry (except at BMH) ☐ Off Telemetry for test/procedure
☐ Initial Telemetry - discontinue in 24 Hours
☐ Consults: _____
☐ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib ☐ Ambulate ☐ Bathroom privileges

DIET:
☑ Regular ☐ Other: _____

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ Saline trap
☑ I & O every 8 hours

Respiratory
☑ O_2 2 L nasal cannula pulse oximeter below 92%
☑ Peak Expiratory Flow on arrival to unit if Asthmatic
☑ Check resting O2 sat.
☑ May titrate oxygen to maintain o2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.

Labs: If not already done in ED.
☑ CBC with diff
☑ BMP

MEDICATIONS:
☑ Solu-Medrol 40 mg IV once if not given in ED
☐ Ipratropium/albuterol nebulizer (DuoNeb)-every 4 hours x4 inhaled
☑ Acetaminophen650mg PO every 4 hours PRN for temp greater than 101°F
☑ Albuterol via hand nebulizer every 4 hours PRN for Shortness of breath or wheezing
☐

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
☐ Patient Low Risk for VTE - No Prophylaxis
☐ Patient anticoagulation initiated
☐ Sequential Compression Device
☐ Enoxaparin (Lovenox) 40 mg subcutaneously daily
☐ Heparin 5,000 units subcutaneously every 8 hours
☐ Heparin 5,000 units subcutaneously every 12 hours
☐ Other _____
☐ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

Atrial Fibrillation

References: Mercy Health - OH (fka Catholic Health Partners) (Epic 2017), Community Health Network (Epic 2017), Lancaster General Health (Epic August 2018), Lee Health (Epic 2018), Rochester Regional Health (Epic 2017)

Champions: Dr. A. Herle

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Patient converts and remains in NSR for over one hour
- Negative diagnostic testing
- Stable condition
- Discuss home medication therapy with cardiologist

Admit to Acute

- Failure to maintain control of rate under 100
- Positive diagnostic testing (as indicated for MI, PE, CHF, etc.)
- Unstable condition

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Allergies & Sensitivities:

☐ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Atrial Fibrillation Observation Order

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ☐ Atrial Fibrillation_____
Admitting Physician: _____
☑Telemetry ☐ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
☑ Initial Telemetry - discontinue in 24 Hours
☐ Consults: _____
☐ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***
CONSIDER DISCHARGE IF: Rate controlled (HR ≤ 110), NO CHF, No evidence of ischemia, asymptomatic
CONSIDER ADMISSION/FURTHER DIAGNOSTIC WORK-UP IF: HR > 110, evidence of CHF, evidence of ischemia or SOB

ACTIVITY:
☑ Bathroom privileges ☐ OOB ad lib ☐ Ambulate with Assistance

DIET:
☑ Low Fat low cholesterol ☐ Regular ☐ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I & O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%
☑ May titrate oxygen to maintain o2 sat greater than 92% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed
☑ Saline trap

Labs: If not already done in ED.
☑ Fasting lipid profile ☑ PT/PTT/INR
☑ CBC with diff ☑ CMP
☑ BNP ☑ Cardiac Markers: Troponin I, draw baseline stat, repeat in 90 minutes, repeat 3 hours
☑ Magnesium ☑ TSH

Diagnostics:
☑ Repeat EKG if change in rhythm ☑ Chest x-ray

MEDICATIONS:
☐ Metoprolol Tartrate 5 mg IV x 1 dose
☐ Cardiazem drip at _____ mg per hour
☐ Lanoxin _____ mg _____
☐ Metoprolol Tartrate _____ mg PO BID
☐ Cardiazem _____ mg PO every _____ hours
☐ Aspirin _____ mg PO daily
Note: Evaluate for anticoagulation and order if indicated
☐ _____

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
☐ Patient Low Risk for VTE - No Prophylaxis
☐ Patient anticoagulation initiated
☐ Sequential Compression Device
☐ Enoxaparin (Lovenox) 40 mg subcutaneously daily
☐ Heparin 5,000 units subcutaneously every 8 hours
☐ Heparin 5,000 units subcutaneously every 12 hours
☐ Other _____
☐ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

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Cellulitis

References: Bayhealth Medical Center (Epic 2017), The Queen's Health Systems (Epic 2017), Lancaster General Health (Epic August 2018), Mount Sinai Health System (Epic 2017), Stanford Health Care (Epic 2017)

Champions: Dr. Thomas Raab, Dr. Thomas Cumbo, Dr. Kevin Shiley

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Orders

- Admit to observation
- Q4 Vital signs, I/O Q8 hrs
- Baseline Labs Protocol

Diltiazem 100 mg /100 ml IV infusion at ____ mg/hr

- DVT Prophylaxis Protocol
- If Lactate in ED greater than 2 mmol/L, repeat Lactic Acid within 3 hours
- Notify physician immediately for:
    - Spreading erythema > 4 cm in 4 hours,
    - Progressive local pain,
    - Resp rate > 25,
    - temperature greater than 101.3,
    - urinary output less than 30ml/hr,
    - systolic BP less than 90 or greater than 160,
    - diastolic BP less than 60 or greater than 110
- Mark edges of cellulitis with indelible marker to monitor progression
- Wound culture and sensitivity if suspected source apparent, prior to antibiotics
- If no penicillin allergy or non-severe allergy:
    - Cefazolin 2 grams intravenous, EVERY 8 HOURS
- For severe Beta lactam allergy:
    - clindamycin (CLEOCIN) IVPB 600, intravenous, EVERY 8 HOURS
- IF history of IV drug abuse or MRSA Add:
    - vancomycin (VANCOCIN) 1 gm IV x 1, then Pharmacy to dose
    - vancomycin (VANCOCIN) 1.5 gm IV x 1; if patient >= 80kg, then Pharmacy to dose

Disposition Criteria

Discharge Home

- Improvement or no progression of cellulitis
- Improved and good clinical condition (ie. No fever, good vital signs) for 8 hrs.
- Able to perform cellulitis care at home and take oral medications

Admit to Acute

- Increase in skin involvement
- Clinical condition worse or not better (i.e. rising temp, poor vitals)
- Unable to take oral medications
- Unable to care for wound at home, home care unavailable

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Cellulitis Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
❑ Consults: _____
❑ Advance Directives: _____
☑ ***Notify MD if: SBP less than 90mmHg or greater than 170mmHg, DBP less than 60 or greater than 110. HR less than 50/min or greater than 120/min,***
RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F

ACTIVITY:
☑ OOB ad lib

DIET:
☑ Regular ❑ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I& O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92% May titrate oxygen to maintain O2 sat greater than 92% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.
☑ Notify Provider: Spreading erythema greater than 4 cm in 4 hours
☑ Notify Provider: Progressive local pain
☑ Nurse Request: Mark edges of cellulitis with indelible marker to monitor progression
☑ Saline trap

Labs: If not already done in ED.
☑ CBC with diff ☑ BMP ☑ CMP ❑ Urinalysis
☑ Lactate, if lactate is greater than 2 mmol/L, repeat lactic Acid within 3 hours
❑ Wound culture and sensitivity if suspected source apparent prior to antibiotics

MEDICATIONS:
❑ Acetaminophen (Tylenol) 650 mg PO q4h PRN mild pain (1-3)
❑ Hydrocodone (Norco) 7.5 mg/acetaminophen 325 mg one tab PO every 4 hours PRN for moderate pain (4-6)
❑ Hydrocodone (Norco) 10 mg/acetaminophen 325 mg one tab PO every 4 hours PRN for severe pain (7-10)
If no penicillin allergy or non-severe allergy:
❑ Cefazolin 2 grams intravenous, EVERY 8 HOURS
For severe Beta lactam allergy:
❑ Clindamycin (CLEOCIN) IVPB 600, intravenous, EVERY 8 HOURS
IF history of IV drug abuse or MRSA ADD:
❑ Vancomycin (VANCOCIN) 1 gm IV x 1, then Pharmacy to dose
❑ Vancomycin (VANCOCIN) 1.5 gm IV x 1; if patient >= 80kg, then Pharmacy to dose

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

PO0100

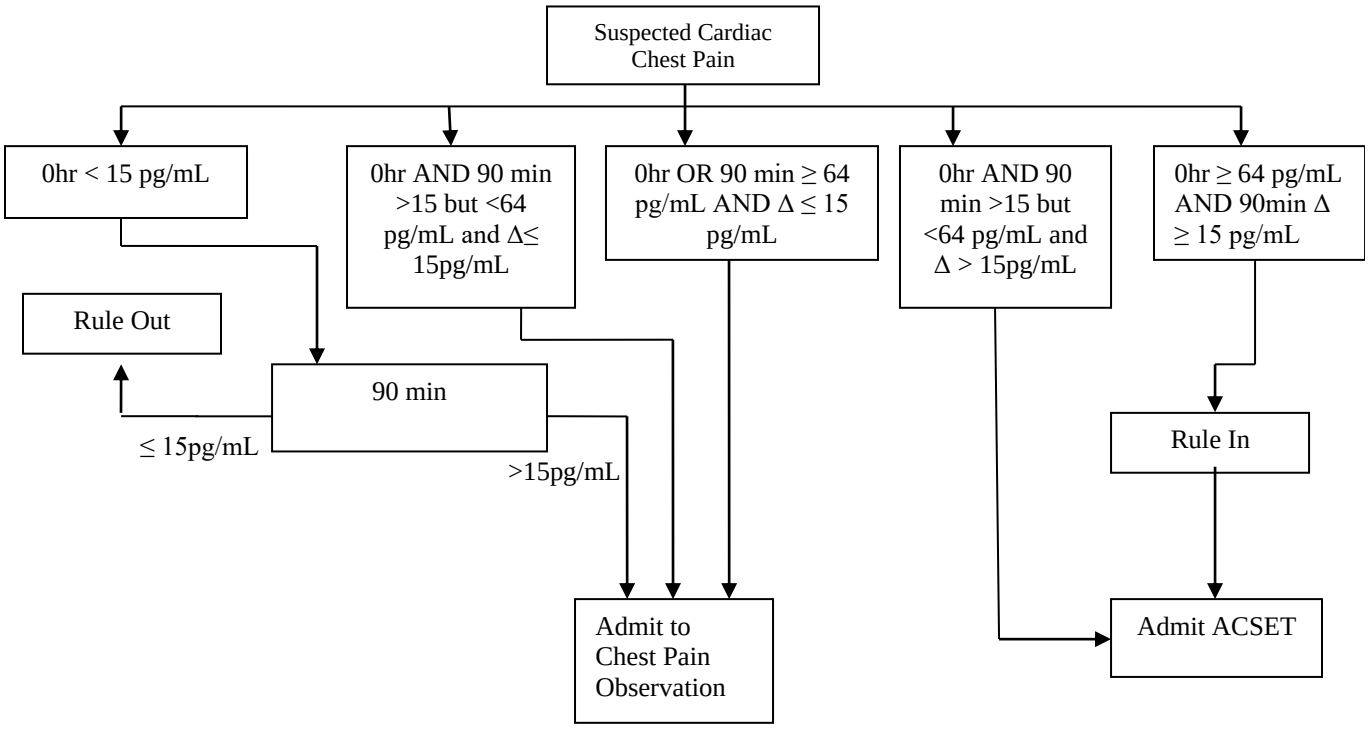
Chest Pain

References: The Queen's Health Systems (Epic 2017), Penn Medicine (Epic 2017), Lancaster General Health (Epic August 2018), Franciscan Missionaries of Our Lady Health System, Inc. (Epic 2018), Kettering Health Network (Epic 2017), Stanford Health Care (Epic 2017)

Champions: Dr. A. Herle

Inclusion and Exclusion Criteria

SUGGESTED INTERPRETATION and GUIDANCE: High-Sensitivity Cardiac Troponin Test (hs-cTnT)



Disposition Criteria

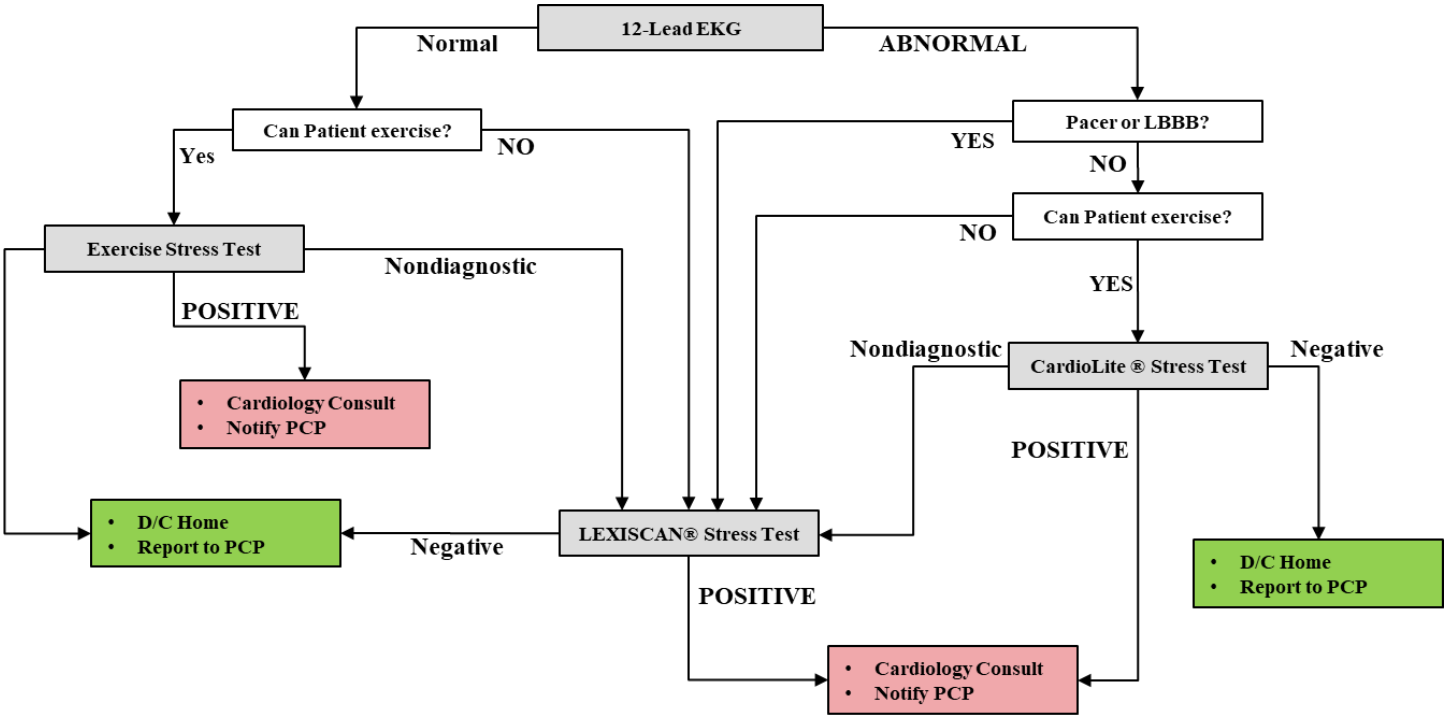
Discharge Home

- High-Sensitivity cardiac troponin test (hs-cTnT) ruling out, as above
- Acceptable Vital, stable symptoms, no serious cause of symptoms identified
- Normal serial cardiac markers and EKGs
- Negative provocative test or cardiac imaging for ACS – no ischemic or reversible defects identified.
- CDU or personal physician discretion

Admit to Acute

- Unstable Vitals
- Positive cardiac markers or EKGs, as above
- Positive provocative test – ischemic or reversible perfusion defect
- Serious alternative diagnosis, e.g. PE, aortic dissection

STRESS TESTING DECISION TREE:



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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

CHEST PAIN OBSERVATION ORDER

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

If patient is diagnosed MI or has acute coronary insufficiency syndrome STOP. Go to appropriate alternative pre-printed order sheets

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ Atypical Chest Pain_____
Admitting Physician: _____
☑Telemetry ❑ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
☑ Initial Telemetry - discontinue in 24 Hours
❑ Advance Directives
❑ Consults: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib

DIET: NO CAFFEINE OR DECAFFEINATED PRODUCTS
☑ Regular ☑ Other: NPO after midnight Prior to Scheduled Stress Testing

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I& O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain O2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed
☑ Saline trap

DIAGNOSTICS: If not already done in ED.
☑ Cardiac Markers: Troponin I, draw baseline stat, repeat in 90 minutes
☑ Fasting lipid profile
☑ CBC/BMP
☑ Repeat EKG if Chest Pain
☑ Stress test **Make sure patient has appropriate apparel for stress test**
❑ Regular (if no EKG abnormalities)
❑ Cardiolite
❑ Lexi scan (if no pulmonary or other contraindications)

OTHER MEDICATIONS:
❑ Aspirin 162 mg to chew now. (If not given in ED).
☑ Aspirin 81 mg PO daily
❑ Other:

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

Dehydration / Vomiting / Diarrhea

Eisenhower Health (Epic 2017), North Memorial Health (Epic August 2018), Mercy Health - OH (fka Catholic Health Partners) (Epic 2017), University of Mississippi Medical Center (Epic 2015)

Champions: Dr. Ralabate

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Acceptable vital signs
- Resolution of symptoms, able to tolerate oral fluids
- Normal electrolytes (if done)

Admit to Acute

- Unstable vital signs
- Associated cause found requiring hospitalization
- Inability to tolerate oral fluids

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Dehydration/ Vomiting/Diarrhea Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
❑ Consults: _____
❑ Advance Directives: _____
☑ ***Notify MD if: SBP less than 90mmHg or greater than 170mmHg, DBP less than 60 or greater than 90, RR less than 12 or greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib

DIET:
☑ NPO, advance to clear liquids as tolerated ❑ Regular ❑ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I & O every 8 hours
☑ Examine abdomen for tenderness, auscultate bowel sounds every 4 hours
☑ Notify MD: urinary output less than 30mL/hr
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain o2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed
☑ Saline trap

Labs: If not already done in ED.
☑ CBC with diff ☑ BMP ☑ CMP ❑ Urinalysis
☑ BMP every 8 hours ☑ CBC with diff every 8 hours

Diagnostics:
❑

MEDICATIONS:
☑ D5 ½ NS IV infusion @125mL/hr
Nausea:
❑ Ondansetron (Zofran) 4mg IV every 6 hours PRN for nausea/vomiting (first choice)
❑ Famotidine (Pepcid) IV 20mg q 12 hours
❑ Pantoprazole (Protonix) IV 40mg q 12 hours

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

Heart Failure Exacerbation

References: Mercy Health - OH (fka Catholic Health Partners), Lancaster General Health (Epic August 2018), University of California San Diego (Epic 2018) • SmartSet/Order Set
Champions: Dr. A. Herle

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Subjective improvement – no chest pain, orthopnea, or exertional dyspnea above baseline
- Acceptable vital signs (O2 sat at baseline or >94%, RR <20HR<100, SBP >100 or baseline,).
- Negative serial ECGs and cardiac markers, good electrolytes, acceptable echo if done
- Evidence of adequate diuresis – 1L urine, decrease in weight, decrease in JVD
- CHF discharge checklist (ACEi, β-blocker, HF/ diet/ smoking education, close followup)

Admit to acute

- New ischemic EKG changes, arrhythmia, cardiac markers, or evidence of cardiac ischemia
- Lack of improvement after 2 doses of diuretic in observation
- Persistent hypoxia, rales, dyspnea
- Need for Inotropes
- Poor response to therapy - Failure to improve subjectively
- Poor home support
- Physician judgment

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Allergies & Sensitivities:

☐ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Congestive Heart Failure Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** Congestive Heart Failure
Admitting Physician: _____
☑Telemetry ☐ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
☑ Initial Telemetry - discontinue in 24 Hours
☐ Consults: _____
☐ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib

DIET:
☑ 2 gram sodium ☐Regular ☐ Low fat low cholesterol ☐ Other:
☑ Fluid Restriction 2000 mL/24hours

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ Weigh daily
☑ Intake and output every 8 hours
☑ Call MD in 6 hours if post diuretic output is less than _____ mL/hour
☑ Saline trap
☑ 60 minutes of CHF Education to be completed prior to discharge
☑ Provide education on smoking Cessation

Respiratory
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%
☑ May titrate oxygen to maintain o2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed

Labs: If not already done in ED.
☑ Cardiac Markers: Troponin I, draw baseline stat, repeat in 90 minutes, 3 hours
☑ CBC with diff
☑ BMP
☑ CMP
☑ Magnesium
☑ PT/INR/PTT
☑ BMP in AM
☑ BNP
☑ ABG (If admission SaO2 is 91% or less on room air)
☑ TSH
☑ Urinalysis

Diagnostics:
☑ EKG on admission Reason: CHF
☑ Chest x-ray Reason: CHF
☐ 2D Echo
☐ MUGA

MEDICATIONS:
☑ Diuretics: Bumex 1 mg IV once
☐ Continue home ACE/ARB, complete admission rec
☑ Lisinopril 5 mg QD if not on ACE/ARB prior to admission
☐ Continue home Beta Blocker, complete admission rec
☑ Carvedilol 3.125mg po BID if not on a beta blocker prior to admission
☐ Spironolactone: _____

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Allergies & Sensitivities:

☐ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Congestive Heart Failure Observation Orders

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☐ Nitrate: _____
☐ Hydralazine: _____
☑ Acetaminophen 650 mg PO every 4 hours Mild pain
☑ Docusate sodium 100 mg PO BID PRN for constipation, hold if diarrhea or abdominal pain
☐ Milk of Magnesia 30 mL PO daily PRN for constipation may repeat once per day if no relief

Referrals;

☑ Please make a discharge appointment with primary medical doctor and/or cardiologist within 7 days of discharge
☑ Care Management
☑ CHS Home Care Evaluation for CHF telemonitoring program evaluation
☑ Cardiac Rehab Referral
☐ Physical Therapy

Venous Thromboembolism Precautions: (VTE) (Must select at least one)

☐ Patient Low Risk for VTE - No Prophylaxis
☐ Patient anticoagulation initiated
☐ Sequential Compression Device
☐ Enoxaparin (Lovenox) 40 mg subcutaneously daily
☐ Heparin 5,000 units subcutaneously every 8 hours
☐ Heparin 5,000 units subcutaneously every 12 hours
☐ Other _____
☐ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

Pneumonia

References: Johns Hopkins Medicine (Epic 2017), Stanford Health Care (Epic 2017), UC Health (Epic 2017)

Champions: Dr. Cumbo, Dr. Shiley, Dr. Raab

CURB-65 Pneumonia Severity Scoring

Symptom	Points
Confusion	1
BUN > 19 mg/dL	1
Respiratory Rate >= 30	1
SBP < 90 mmHg, DBP =< 60 mmHg	1
Age >= 65	1

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Subjective and clinical improvement during CDU stay
- Acceptable vital signs during observation period
- Patient able to tolerate oral medications and diet
- Physician discretion

Admit to Acute

- Patient not subjectively improved enough to go home
- Lack of clinical progress or clinical deterioration.
- Unable to safely discharge for outpatient management

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Allergies & Sensitivities:

☐ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Pneumonia Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ☐ _____
Admitting Physician: _____
☐ Consults: _____
☐ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib

DIET:
☑ Regular ☐ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I & O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain O2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.
☑ Saline trap

Labs: If not already done in ED.
☑ CBC with diff ☑ CMP ☑ Sputum culture ☑ Urine legionella Antigen ☑ Streptococcus Pneumonia Antigen
☑ Nasopharyngeal swab for Influenza
☐ ABG ☐ Urine ☐ Blood cultures x2 prior to administration of antibiotics

Diagnostics:
☐ EKG

MEDICATIONS:
☐ Prednisone 40mg PO daily (preferred if pt can take oral)
☐ Methylprednisolone (Solu-Medrol) 40 mg IV daily (if pt cannot take oral)
☐ Albuterol (Ventolin) 2.5 mg via HHN every 4 hours
☐ Albuterol (Ventolin) 2.5 mg via HHN every 2 hours prn shortness of breath
☐ Ipratropium (Atrovent) 0.5 mg via hand held nebulizer every 6 hours

Antibiotics:
Community Acquired Pneumonia <u>Non-ICU Patient</u>:
☐ Ceftriaxone (Rocephin)1gram IV q 24 h + azithromycin (Zithromax) 500mg PO q 24 h
OR
☐ Ceftriaxone (Rocephin)1gram IV q 24 h + azithromycin (Zithromax) 500mg IV q 24 h
If patient has a severe penicillin allergy or a cephalosporin allergy, please choose one of the following:
☐ Levofloxacin (Levaquin) 750 mg PO q 24 h
☐ Levofloxacin (Levaquin) 750 mg IV q 24 h

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
☐ Patient Low Risk for VTE - No Prophylaxis
☐ Patient anticoagulation initiated
☐ Sequential Compression Device
☐ Enoxaparin (Lovenox) 40 mg subcutaneously daily
☐ Heparin 5,000 units subcutaneously every 8 hours
☐ Heparin 5,000 units subcutaneously every 12 hours
☐ Other _____
☐ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

PO0100

Revised 6/19
CSC Form # 9024

Syncope

References: Stanford Health Care (Epic 2017), Franciscan Missionaries of Our Lady Health System, Inc. (Epic 2018), University of California San Diego (Epic 2018)
Champions: Dr. A. Herle

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Benign CDU course, stable vital signs
- No arrhythmia documented on review of cardiac monitor history screens
- Acceptable home environment
- Follow up with possible, Holter event monitor PRN

Admit to Acute

- Deterioration of clinical course
- Significant testing abnormalities
- Unsafe home environment

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

SYNCOPE OBSERVATION ORDERS

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
☑Telemetry ❑ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
(***Must select one reason listed below)***
☑ Initial Telemetry - discontinue in 24 Hours (pre and post intervention, pacemaker, PCI, defibrillator, peripheral vascular intervention, continuous IV infusions, inotropic meds, stable CHF, Post-op Abdominal Aortic Aneurysm Repair or carotid endarterectomy.
❑ Consults: _____
❑ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ OOB ad lib ❑ Ambulate ❑ Bedrest/Bathroom privileges

DIET:
☑ Regular ❑ 2 gram Sodium

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours
☑ Neuro checks every 2 hours x3 then every 4 hours
☑ Orthostatic B/P on admission every 2hours x3, then every 4 hours
☑ I & O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain O2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.
☑ Saline trap

Labs: If not already done in ED.
☑ BMP
☑ Magnesium
❑ CBC with diff
❑ Stool for OB
☑ Urine toxicology
❑ Urinalysis
❑ Urine Pregnancy Test

Diagnostics
☑ EKG ❑ Chest X-Ray ❑ Echocardiogram ❑ EEG

Medications:
❑ _____
❑ _____

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

PO0100

Transient Ischemic Attack

References: Oregon Health & Science University (Epic 2014), North Memorial Health (Epic August 2018), Mount Sinai Health System (Epic 2017), UC Health (Epic 2017)

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- No recurrent deficits, negative workup
- Clinically stable for discharge home (on Asa – 81mg/day)
- Physician judgment

Admit to Acute Care

- Recurrent symptoms / deficit
- Evidence of treatable vascular disease - ie >50% stenosis of neck vessels
- Evidence of embolic source requiring treatment (ie heparin / coumadin) - ie mural thrombus, Paroxysmal atrial fibrillation
- Unable to complete workup or safely discharge patient within timeframe

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Transient Ischemic Attack-TIA Observation Order

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
☑Telemetry ❑ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
☑ Initial Telemetry - discontinue in 24 Hours.
❑ Consults: _____
❑ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***
☑ **NIHSS Admission score documentation (order to drop NIHSS assessment)**
☑ **Get With the Guidelines (GWTG) Stroke Risk Factor Assessment Tool (order to drop GWTG Stroke assessment)**

ACTIVITY:
☑ OOB ad lib

DIET:
☑ Regular ❑ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs with Neuro Checks every 4 hours x 24 hours, then every 8 hours ☑ I & O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain o2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed
☑ Saline trap
☑ Elevate head of bed 30 degrees

Labs: If not already done in ED.
☑ lipid profile ☑ CBC with diff ☑ BMP ☑ Hemoglobin A1C with Estimated Average Glucose Routine AM Next Day

Diagnostics: If not already done in ED.
☑ CT head - Reason: TIA ☑ ECHO 2D – Reason: TIA

MEDICATIONS:
❑ Aspirin EC 81mg PO daily
❑ Aspirin EC 325mg PO daily
❑ Clopidogrel (Plavix) 75 mg PO daily
❑ Ticagrelor (Brilinta) 90 mg PO BID
❑ Acetaminophen (Tylenol) 650 mg PO q4H PRN temp greater than 37.5 C (99.4 F) or Mild Pain 1-3
❑ Atorvastatin (Lipitor) 80 mg PO QHS
❑ Rosuvastatin (Crestor) 20 mg PO daily
❑ Pravastatin (Pravachol) 40 mg PO daily
❑ Ondansetron (Zofran) 4 mg IV q6 hrs PRN nausea/vomiting
❑ Bisacodyl (Dulcolax) suppository 10 mg rectally every other day PRN constipation
❑ Sennosides/Docusate Na 8.6/50 (Senokot-S) 1 tab PO BID – hold for loose stools

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____

PO0100

Revised 6/19
CSC Form # 9024

Dizziness/Vertigo

References: Spectrum Health (Epic 2017), Allina Health System (Epic 2017), Johns Hopkins Medicine (Epic 2017), Edward-Elmhurst Healthcare (Epic 2018)

Champions: Dr. Dofitas, Dr. Babu

Observation and Acute Admission Criteria: Reference InterQual 2019 Physician Reference Guide

Disposition Criteria

Discharge Home

- Symptom improvement, ability to ambulate
- No recurrent deficits, negative workup
- Clinically stable for discharge home (on Asa – 81m
- Physician judgment

Admit to Acute

- Recurrent symptoms / deficit
- Evidence of treatable vascular disease - ie >50% stenosis of neck vessels
- Evidence of new focal neurologic lesion
- Unable to safely discharge patient within 48 hours
    - daily scheduled

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Allergies & Sensitivities:

❑ No Known Allergies ☑ (Indicates automatic order. Prescriber to draw line through orders to discontinue)

Dizziness/Vertigo Observation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

Check In: ☑ **No Procedure** - Referred as Observation/Outpatient
Location: _____ **Diagnosis/Reason for Admission:** ❑ _____
Admitting Physician: _____
☑Telemetry ❑ Remote Telemetry (except at BMH) ☑Off Telemetry for test/procedure
☑ Initial Telemetry - discontinue in 24 Hours
❑ Neurology Consult: _____
❑ Advance Directives: _____
☑ ***Notify MD if: BP less than 90mmHg or greater than 170mmHg, HR less than 50/min or greater than 120/min, RR greater than 24/min, SPO_2 less than 92%, Temp less than 95°F or greater than 101°F***

ACTIVITY:
☑ Ambulate with assistance ❑ OOB ad lib ❑ Bathroom privileges ☑ PT Evaluation

DIET:
❑ NPO pending swallow eval ❑ Regular ❑ Other:

NURSING ASSESSMENTS/INTERVENTIONS
☑ Vital Signs every 4 hours x 24 hours, then every 8 hours
☑ I & O every 8 hours
☑ O_2 2 L nasal cannula for chest pain/SOB/or pulse oximeter below 92%. May titrate oxygen to maintain o2 sat greater than 94% by 1 liter/min. Notify Provider if 4liter/min adjustment is needed.
❑ Bedside Swallowing eval, if failed: Speech therapy to evaluate
☑ Saline trap

Labs: If not already done in ED.
☑ CBC with diff ☑ BMP ☑ PT/PTT/INR

Diagnostics:
☑ Carotid imaging with MRI/MRA - to detect surgical carotid stenosis (>50%) and microinfarct
- o If contraindications to MRI/MRA and good renal function, then CTA of head and neck vessels
- o If contraindications to MRI/MRA and poor renal function, then carotid doppler

MEDICATIONS:
Nausea:
❑ Ondansetron (Zofran) 4mg IV every 6 hours PRN for nausea/vomiting (first choice)
❑ Famotidine 20 mg IV q 12 hours

Venous Thromboembolism Precautions: (VTE) (Must select at least one)
❑ Patient Low Risk for VTE - No Prophylaxis
❑ Patient anticoagulation initiated
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❑ Heparin 5,000 units subcutaneously every 8 hours
❑ Heparin 5,000 units subcutaneously every 12 hours
❑ Other _____
❑ VTE Pharmacological Prophylaxis Contraindicated:
Please document reason: _____

Prescriber Signature: _____