COMMUNITY PARAMEDIC SERVICES

All patients referred for a community paramedic visit will receive a complete history and physical evaluation. Dependant on physician order and/or patient needs further assessment, prevention, and intervention services are available.

Assessment/prevention services.

1. Chronic disease evaluation and monitoring including but not limited to;
    a. Diabetes
    b. Cardiovascular Disease
    c. Pulmonary Disease
    d. Mental Health
    e. Orthopedic concerns
    f. Obesity/nutritional concerns

2. Wound evaluation and staging
3. Medication reconciliation and prescription drug compliance monitoring
4. Specimen collection for laboratory analysis
5. Immunizations/vaccinations
6. Fall risk assessment
7. Home safety assessment
8. Psychosocial evaluation
9. Other medical interventions/assessments as indicated

Intervention/Management

1. Breathing treatments
    a. Aerosolized treatments(scheduled)
    b. Peak flow testing and tracking

2. Intravenous monitoring and or medication administration
    a. Tracking of infused volume
    b. On-site assessment of equipment function
    c. Addition or infusion of medications as ordered by physician

3. Specimen collection
    a. Blood draw for return to lab
    b. On-site blood glucose testing
        i. Weekly, pre-post medication or meal

c. Urine collection return to lab
d. Chem -9 analysis may be completed on site

4. Wound care
    a. Dressing changes
    b. Infection monitoring

4. Fall/ Risk assessment
    a. Evaluation of living quarters for determination of possible hazards which could lead to a fall
    b. Includes interior and exterior of living area
    c. Recommend changes if indicated

5. Home safety Assessment
    a. Evaluation of overall living environment

6. Psychoscocial
    a. Identify patient needs and provide contact with available community resources
        i. North social worker
        ii. Food shelves
        iii. Job assistance
        iv. Financial resources
        v. Transportation options
        vi. Others as indicated

Future option of obtaining ECG, at this point monitor would be huge expense and there is not an abundant supply to burrow from the Ambulance side.
immediatelyimmediatelyimmediatelyimmediatelyimmediatelyimmediatelyimmediatelyAlso as far as I know there is not the capability currently to immediatly send ECG to a physician for review.
normallynormallynormallynormallynormallynormallynormallynormallynormallynormallyTo make it work we would have to have a dedicated monitor and a dedicated MD to send to- huge liability if there are new abnormalities, all the CP's can identify a STEMI and would know to initiate EMS/911 for transport/intervention but many of these people will have normaly abnormal ECG's to begin with and comparing to old tracing or sending for MD review would be needed so new changes wouldn't be missed.

Date:

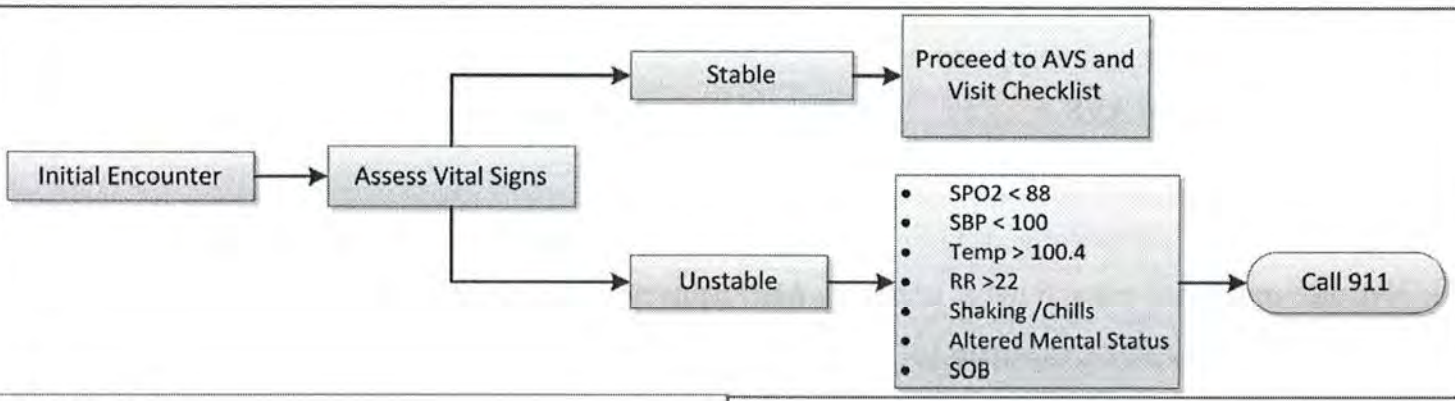
Firefighter Home Visit

☐ *Patient Declined Visit*

Name: Age: Time Called:

MRN: Provider: Time Scheduled:

Address: High Risk: Time In: Time Out:



Visit Checklist

- ☐ Follow Up Appointments
- ☐ Medications
- ☐ Who to call
- ☐ Red Flags
- ☐ Smoke Alarm Present and Working
- ☐ CO Alarm Present and Working
- ☐ PEAT Assessment Score_____
  - 7-16 → Call Adult Protection (612) 348-8526
  - 17-27 → Call Health Department (

Medical:

Temp_____ BP_____ HR_____RR_____SPO2____

Weight_____ ☐ RA

Gen Appearance: ☐ O2

Comfortable Uncomfortable

Pain:

Controlled Uncontrolled

Respiratory:

Labored Unlabored

General comments:

Outcomes:

- ☐ Visit Complete
- ☐ Not Home
- ☐ PN Care Team (952) 993-9555
  - ♦ After 5pm/ Weekend/Holiday
- ☐ 911
- ☐ Social /Community Resources
- ☐ Adult Protection (612) 348-8526
- ☐ Home Care (Phone Number on AVS)
- ☐ Medication Follow Up
- ☐ High Risk Follow Up
- ☐ Installed Smoke / CO Detectors

Comments:

- ☐ Missed Items on Checklist
- ☐ Medication Questions
- ☐ Pain Management → Call PN Care Team

Other:

Name: _____

Department: _____

Signature: _____

Date: _____ Time: _____

If calling PN Care Team: Identify self as a Firefighter and ask for Methodist Emergency Department Line.

HIM Fax: (952) 993-6496 Pages ____ of ____.

Discharge Specific Diagnosis:

Asthma / COPD/ Pneumonia:

☐ Inhaler Questions => If yes, medication follow up.

☐ Asthma Action Plan

CHF:

☐ Weight Log

☐ CHF: If / Then from AVS

☐ Weight gain

Diabetes:

☐ Hyperglycemia (increased thirst & urination, ABD pain) => If yes, call PN Care Team.

☐ Hypoglycemia: (shaking, sweating,) If yes, => check blood sugar and call PN Care Team.

☐ Blood Sugar Log

Post Surgical:

☐ Pain => If uncontrolled call PN Care Team

☐ Functional Status since Home (Bathroom, Dressing, questions) => If yes, contact PN Home Care

If Additional Concerns Call PN Care Team:

- (952) 993-9555
- *When calling PN Care Team: Identify self as a Firefighter and ask for Methodist Emergency Department Line.*

Physical Environment Assessment Tool (P.E.A.T. scale)

Dwelling (select All that apply)		Cleanliness (select one)		Social structure (select one)		Hazards (select one)	
Enclosed shelter	2	Immaculate (no clutter)	4	Lives with other(s)	12	None	12
Electricity	2	Clutter (non-biodegradable items scattered)	3	Lives alone	9	Possible (household items unsafe or improperly stored)	9
Running water (Potable water in home)	2	Small bio. waste	2	Verbal abuse/neglect	6	Probable	6
Temperature safe for proper health	2	Large bio. waste	1	Physical abuse/neglect	3	Certain	3
Add up (0-8)		Score (1-4)		Score (3-12)		Score (3-12)	

Total Score:

Table 1: Guidelines for Patient Visits (COPD, Diabetes, HF, Mental Illness)

Before Initial Visit

Diagnoses
Biochemical markers
Health Care Providers' goals
Prescribed Medications and OTCs
ADLs

First visit

Weight, BMI, Recent weight change (if any)
Blood Pressure in home
Nutrition Prescription by Health Care Provider
Medication Reconciliation
Nutrition Survey (** Note to editor: insert reference)
Nutrition Behavior Change Scale (** Note to editor: insert reference)
Review of available food in the home
Available resources
Identification of patient-centered goal(s)
Based on assessment and goals identify tools to use
Tracking records such as fluid consumption, etc. (if warranted) (** Note to editor: insert reference)
Document treatment plan and summarize for Health Care Provider
Refer to Health Care Provider if warranted

Second Visit

Weight (note any weight change)
Blood pressure in home
Review any changes in provider orders
Assess any changes on Nutrition Survey and/or Behavior Change Scale
Assess achievement of goal(s)
If goal(s) not met, reevaluate goal(s) and teaching tools
Answer questions or concerns
If goal(s) met, build on goals
Update treatment plan and summarize for health care provider
Develop long term goals and with plans on future care
Refer to Health Care Provider is warranted.

Third & Subsequent Visits

Build on previous visits

Nutrition Survey

How many meals do you usually eat in a day?
** Note to editor insert link:

- Nutrition Care Manual "Power Up with Breakfast"
- Nutrition Care Manual "Eating Right for Older Adults"

Breakfast?	Yes __	**What time?** **What foods do you typically eat for breakfast?**
	No __	**Would you be willing to explain why you don't eat breakfast?**
Lunch?	Yes __	**What Time?** **What foods do you typically eat for lunch?**
	No __	**Would you be willing to explain why you don't eat lunch?**
Dinner?	Yes __	**What time?** **What foods do you typically eat for dinner?**
	No __	**Would you be willing to explain why you don't eat dinner?**

Do you have other meals or snacks during the day or night?
** Note to editor insert link Nutrition Care Manual "Healthy Snacks"

No __	
Yes __	**How many snacks in a typical 24 hour period? __** **What Times?_____** **What do you eat for snacks?**

Has your appetite changed lately?

No __	

Yes __	**Have you lost weight? No __ Yes __ How much? ___ (pounds)** **Have you gained weight? No __ Yes __ How much? ___ (pounds)**

Do you use any nutritional supplements?

No __	
Yes __	**Which supplement (for example, Boost, Ensure, protein powder, etc.)?** **How much / how often?**

Do you take vitamins and/or other supplements (herbals, omega 3, etc.)?
** Note to editor insert link to "Food Sources of Vitamins & Minerals"

No __	
Yes __	**What kind of vitamins?** **How much / how often?**

Do You have any of the following problems?
** Note to editor insert link:

- Vitamin & Mineral Deficiencies"
- (Link to Nutrition Care Manual "Heart Healthy Shopping Tips")
- (Link to Nutrition Care Manual "Heart Healthy Cooking Tips")
- (Link to Nutrition Care Manual "Nausea and Vomiting"
- (Link to Nutrition Care Manual "Constipation"
- (Link to Nutrition Care Manual " Chewing and Swallowing"

Food allergies or sensitivity?	No __	
	Yes __	Which foods?
Nausea or vomiting?	No __	
	Yes __	How many times in a week? Do you know what causes it (explain)? Have you seen a health care provider about this?
Problems chewing or swallowing	No __	
	Yes __	Do you know what causes it (explain)? Have you seen a health care provider about this?
Frequent constipation or diarrhea?	No __	
	Yes __	Do you know what causes it (explain)? Have you seen a health care provider about this?

Lost interest in food?	No __	
	Yes __	What caused you to lose interest? Have you seen a health care provider about this?
Some food just doesn't taste good anymore.	No __	
	Yes __	Which foods? Have you seen a health care provider about this?

Do You have trouble with any of the following that prevent you from following your health care provider's instructions about meals?

Eyesight?	No __	
	Yes __	Have you explained this to your health care health care provider?
Hearing?	No __	
	Yes __	Have you explained this to your health care health care provider?
Shopping for food or getting to the grocery store?	No __	
	Yes __	Explain?
Meal preparation or cooking?	No __	
	Yes __	Explain?
Do you feel you understand your special diet needs?	No __	
	Yes __	Explain?
Any other problems related to foods (for example, uncontrolled eating or fearful of eating?	No __	
	Yes __	Explain?

WHEN TO CALL THE DOCTOR

CONDITION	EMERGENCY -Call at time of event-	NON-EMERGENCY -Next Business Day-	ROUTINE -Next Visit-
Altered Mental Status	Sudden change in mental status		Gradual change in mental status
Bleeding	Uncontrolled or repeat episode within 24 hours - prolonged nosebleed - bloody emesis - bloody stools not from hemorrhoid - profuse vaginal bleeding - grossly bloody urine		Controlled - no further episodes - bleeding from hemorrhoid that is controlled
Chest pain	New onset, or not relieved in 20 minutes by NTG X3 Increased frequency in episodes		
Death of a resident ** Be sure to also check the policy on when to call the coroner **	Unexpected death	Expected death	
Diarrhea	Acute onset with multiple stools (> 3 stools) and change in VS, temperature > 101, or altered mental status after check for impaction.	Persistent loose stools, stable vital signs, temperature < 101	
Edema	Abrupt onset unilateral edema with tenderness, redness	Gradually progressive unilateral or bilateral	
Emesis	>3 episodes in 24 hrs, Bloody, coffee grounds, associated pain, assoc. with change in vital signs	Repeat episodes (<3 in 24 hrs) Emesis with sx: - diarrhea	
Falls	Abnormal neuro exam: Immediately or on recheck. Pupil change. Confusion. Laceration with bleeding. Musculoskeletal deformity. Hip pain.	Without injury or change in function	
Family Concerns	Demand to speak to physician or have assessment now.	Persistent, recurrent concern that may need physician attention.	
G, J or G-J-Tubes	If unable to replace immediately if removed	Leaking, intolerance to feeding.	

WHEN TO CALL THE DOCTOR

Labs:	Abnormal for resident and symptomatic	Abnormal without symptoms	
Medication Errors	If resident is symptomatic due to the error. -wrong patient received hypoglycemic agent		No symptoms
Pressure Sores		Grade II or higher; or any break in skin associated with fever or signs of skin infection	
Seizures	New onset, suspected, and/or persistent	Self limited with known history and on medication.	
Shortness of Breath	Acute onset or with chest pain, change in vital signs, labored breathing.	Partial response to treatment	
Skin rash	Rash in someone on a new medicine	Unresolved or recurrent	
Vital Signs (Unless values are consistently at this level and the physician is aware)	Systolic: >195 <90 Diastolic: >115 Pulse: >140 <50 Resp.: >28 <10 Oral Temp.: >101.5 ***REMEMBER** standing orders for Tylenol are only for pain**	Weight loss 3-5 lbs. in one week or 5% in one month	
Glucose	Follow diabetic standing orders	Follow diabetic standing orders	Follow diabetic standing orders
X-ray	Fracture, pneumonia, small bowel obstruction.		

These guidelines are not intended to substitute for good nursing judgment. If the nurse feels uncomfortable with a situation s/he should not delay in contacting a physician.

CHF Protocol Implementation Plan

LTC Professionals, PLLC is dedicated to the development of high quality programs that serve the skilled nursing facility and long term care market. This is achieved through high quality practitioners and efficient, well-implemented service lines that address the key needs of residents, facilities, and quality metrics.

We strive to continuously improve the quality of care delivered to our patients, reduce hospitalizations and ER visits and improve the environment in which they reside, whether temporarily or permanently.

CHF Protocol Implementation Plan

CHF Protocol Outline

CHF is one of the leading causes of readmission to the hospital and ER visits. There are a number of strategies in the SNF setting that are possible to decrease the risk of hospitalization, increase the quality of care and improve the resident's quality of life. The literature has demonstrated that very few patients are on maximal therapy, that monitoring for symptoms is inadequate and that the monitoring of weights and vitals is suboptimal.

In order to overcome these barriers, we propose a phased approach.

Phase 1: Jan/Feb 2012

Correct identification of acute systolic and diastolic CHF patients and at-risk patients for exacerbation of CHF.

Consistent measurement of edema, vital signs and weights

Introduction of CHF symptom flow sheet (see attached)

Phase 2: Mar/Apr 2012

Develop protocol for lab monitoring and for titration of medication

Introduction of cardiac rehab protocol for all CHF patients

Dietary recommendations for CHF patients

Phase 3: May/Jun 2012

Introduction of CHF clinic to specifically manage CHF patients using a physician extender model with physician oversight to maximize medical therapy and to monitor labs appropriately

CHF Protocol Implementation Plan

Measures of Success

• Identify patients with heart failure	100%
• Patients on beta blocker/ACE I for systolic heart failure	90%
• EF Measured in the last 1 year	100%
• Readmission rate	10%
• Emergency room visits for heart failure exacerbation	Decrease by 50%

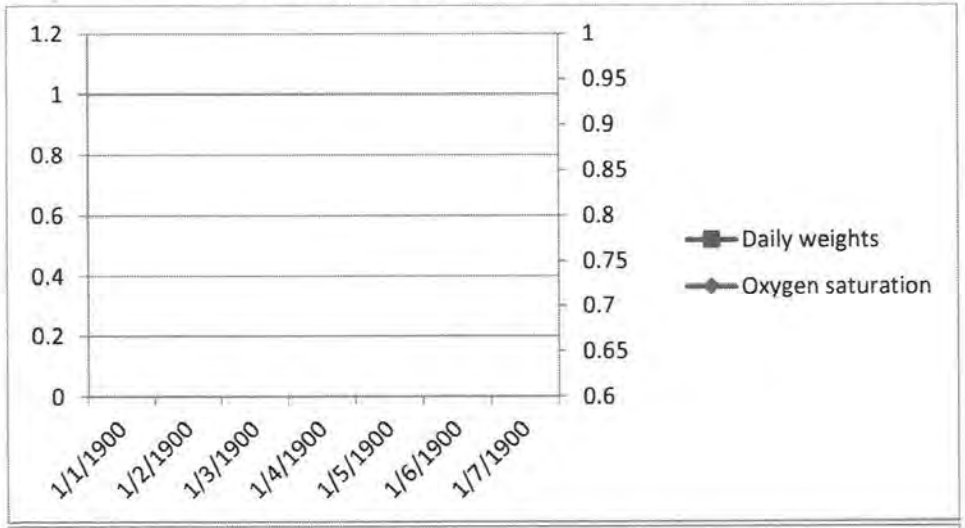
Current state

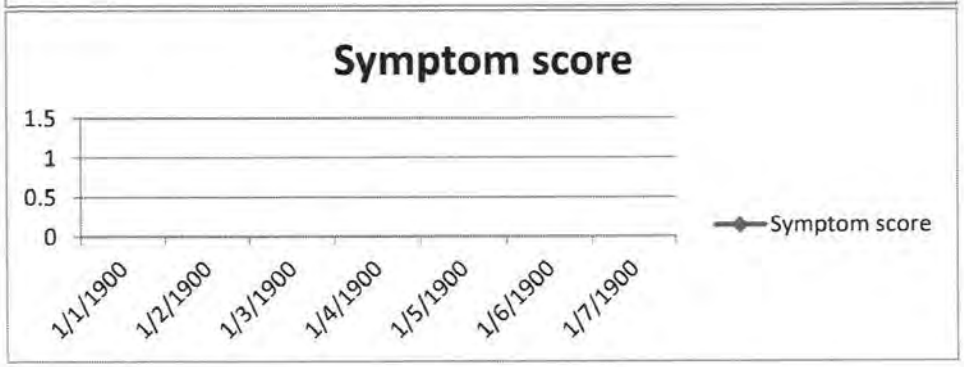
- Review current 30 day readmission
- Identify patients with heart failure (acute or chronic)
- EF measurement in last year of not documented

Process Improvement

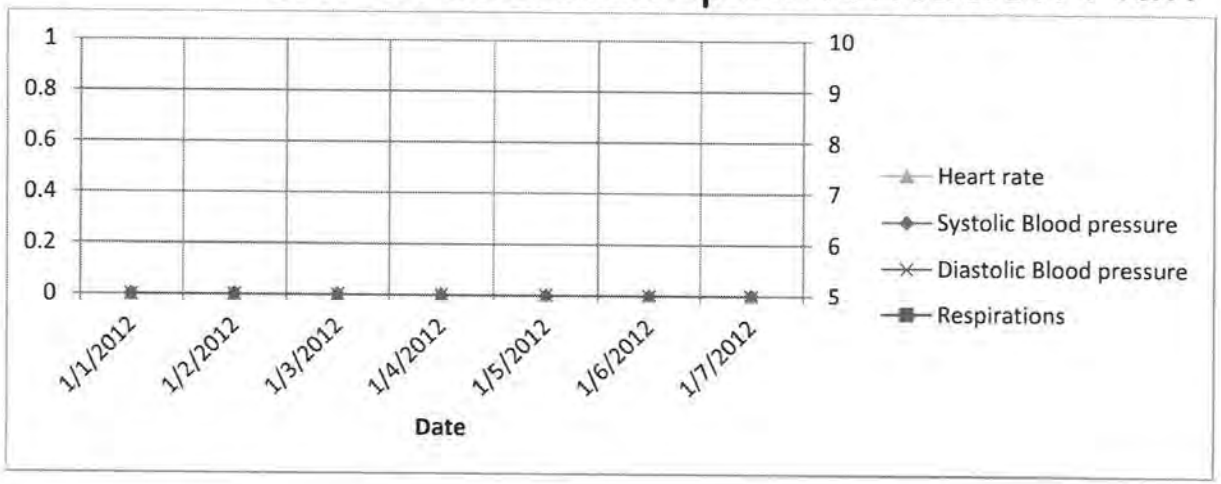
- Implement a process improvement team lead by physician to discuss current process map
- Interdisciplinary team will be champions of change
- Identify future state
- Identify key processes that effect outcomes
- Institute a PDSA process improvement model

CHF Protocol Implementation Plan





CHF Protocol Implementation Plan



CHF Protocol Implementation Plan

Date	1/1/2012	1/2/2012	1/3/2012	1/4/2012	1/5/2012	1/6/2012	1/7/2012
Vitals							
Oxygen saturation							
Respirations							
Heart rate							
Systolic Blood pressure							
Diastolic Blood pressure							
Daily weights							
Symptoms (check symptoms present)							
Shortness of breath (at rest)							
Dyspnea with exertion							
Paroxysmal nocturnal dyspnea							
Orthopnea							
Chest pain							
Palpitations							
Edema							
Lightheadedness							
Symptom score							
Risk Factors							
Atrial fibrillation							
Coronary artery disease							
Diabetes							
Stroke							

Management of Hemoglobin

Hgb 8.0-10.0, no significant bleeding

Notify MD of Hgb result and check weekly x 1, if stable check CBC in 1 week

If Hgb increasing no changes

If Hgb decreasing, notify MD

If Hgb < 8.0, no significant bleeding

Notify MD of Hgb result and check weekly

If Hgb < 8.0, with bleeding

Notify MD, send to the ER for evaluation

Recommendations for Anticoagulation Therapy

Indication	Desired Range	Target	Duration of Therapy
Atrial fibrillation	2.0 – 3.0	2.5	Lifelong
CVA / TIA	2.0 – 3.0	2.5	Lifelong
Pulmonary embolism Reversible or time limited risk factors, first event	2.0 – 3.0	2.5	3 – 6 months
Pulmonary embolism Recurrent, or first event with continuing risk factors	2.0 – 3.0	2.5	Lifelong
Venous thromboembolism Reversible or time limited risk factors, first event	2.0 – 3.0	2.5	≥ 3 months
Venous thromboembolism Recurrent, or first event with continuing risk factors	2.0 – 3.0	2.5	Lifelong
Acute myocardial infarction	2.0 – 3.0	2.5	3 months
Bioprosthetic (tissue) valve	2.0 – 3.0	2.5	3 months
Mechanical valve (high risk)	2.5 – 3.5	3.0	Lifelong
Bileaflet mechanical valve (St Jude Medical, CarboMedics or Medtronic-Hall tilting disk aortic valve) in aortic position, normal size left atrium, NSR	2.0 – 3.0	2.5	Lifelong

Reference: Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy (*Chest 2004; 126; 163S-703S*).

Dosing Initiation

New or newly hospital discharged patients on Warfarin should be co-managed in consultation with provider managed until stable dosing (within therapeutic range) has occurred for at least 2 weeks, with 2 consecutive INR's within target range. Plans for dose changes and follow up lab visits should be discussed with the provider until the patient's anticoagulation therapy is deemed stable by the provider. The INR should be checked within 5-7 days after a hospitalization.

1. Begin with 5 mg daily: recheck INR after 2-3 doses. The PCP or ordering provider name must be on the referral. Consider a lower starting dose if:
    a. The patient is > 75 years old
    b. Has multiple co-morbid conditions
    c. Interacting medications increase the INR
    d. Poor nutrition (low albumin)
    e. Elevated INR when off Warfarin
    f. Impaired liver function
    g. Changing thyroid status
2. A baseline INR value may be drawn to rule out underlying coagulopathy.
3. If the INR is ≥ 2.0, after the first 3 doses, consider decreasing the dose by one-half. Always search for causes of a rapid rise in INR.
4. Subsequent INR values are determined at:
    a. 2-3 times weekly for 3 weeks until 2 consecutive INR's are within target range.

b. Then check weekly INR's until 2 consecutive INR's are within target range.
c. Then check INR's every 4 weeks.

5. Steady state anticoagulation occurs between 6 and 12 days. Expect obese patients, oncology and elderly patients to have a longer time to reach a steady state.

Drug Interactions: All new medications will be checked for warfarin interaction. The following are proven **MAJOR*** interactive drugs and should be managed as follows:

Amiodarone	Causes inhibition of Warfarin metabolism---increases INR: Decrease weekly Warfarin 10-30% and recheck in 1 week. Check weekly. INR should be stable 3 weeks after starting Amiodarone and after a dose change. Over time, Amiodarone stabilizes after 3 weeks.	Then check weekly until dose is stable, resume management per protocol.
Carbamazepine	Induction of Warfarin metabolism---decreases INR by 40%: increase Warfarin dose by 10-20% and recheck within 1 week.	
Chemotherapeutic Drugs	Some chemo drugs have a delayed effect and some an immediate effect which may affect the INR. Refer to each specific agent. The majority increase the INR.	
Erythromycin and many other Antibiotics.	Inhibitor of 2 enzymes that degrade Warfarin---causes significant increase in INR: recheck in 3-5 days. May need to decrease dose 10-20%. Most antibiotics disrupt the flora in the intestines thus may affect the INR. Keep in mind the duration of the antibiotic. You may need to decrease the Warfarin dose.	Consider antibiotic duration; recheck in 3 days then 5-7 days post treatment with antibiotics, then resume per protocol.
Metronidazole (Flagyl)	Affects enzyme 2c9—significantly increases INR. May need to decrease dose 10-20% and recheck in 3-5 days. Keep in mind the duration of Flagyl/Metronidazole.	Consider antibiotic duration; recheck in 3 days then 5-7 days post treatment with antibiotics, then resume per protocol.
Phenobarbital, Primidone, Levothyroxine	Increase catabolism of Vitamin K clotting factor---increases INR with stable anticoagulation therapy, is gradual over 2-3 weeks, have patient recheck INR in 1 week.	Monitor 1-2 weeks post initiation and again 1-2 weeks post discontinuation
Rifampin	Induces hepatic enzymes that metabolize Warfarin—significant decreases in INR, takes 2-3 weeks for full affect on INR. 20-50% increases in Warfarin dosing is necessary to keep INR within range.	Monitor for 1-2 weeks post initiation and again 1-2 weeks after completion of Rifampin.
Steroids/Corticosteroids	Has the potential to increase the INR. Consider chronic vs. initial therapy of steroid. Check INR within 3-5 days and monitor closely while tapering doses. If the patient is on chronic steroids before initiation of anticoagulation program, chances are INR will be stable.	Consider duration, if short term use, recheck in 3-5 days and 5-7 post treatment, then resume per protocol.
Trimethoprim/Sulfa Methaxazole/Bactrim	Inhibition of Warfarin metabolism---increases INR: Consider reducing weekly Warfarin dose by 10-20% and rechecking in 3 days. Consider the duration of the antibiotic and recheck in 5-7 days there after.	Consider treatment duration, recheck in 3 days then 5-7 days post treatment, then resume per protocol.
Fenofibrate (Tricor, Triglide, Liopfen, Fenoglide, Antara)	Has the potential to increase the INR. Check INR weekly for 4-6 weeks. May have to decrease Warfarin dose by 10-20% weekly.	Then resume per protocol when therapeutic range is established.

Major interactive drugs identified by the Allina Drug Information Service
Also identified by ACCP Conference on Antithrombotic and Thrombolytic Therapy, CHEST supplement 2004
Up-to-Date, 2010

Maintenance Management

1. All dose changes based on TOTAL WEEKLY DOSE. In general, a 10% dose adjustment will result in approximately 0.7-0.8 INR change, and a 15% dose adjustment will result in a 1.0 INR change (Institute for Clinical Systems Improvement).
2. When evaluating an INR result, always verify compliance including:
    a. Tablet strength and dose,
    b. New medications,
    c. Alcohol use/abuse,
    d. Change in diet (such as an increase in salads in the summer, green tea, meals on wheels)
    e. And general health.

Guideline for the adjustment of Warfarin dosage based on INR (this entire section has been revised)

Low INR range desired (Target Range = 2.0 - 3.0)

INR Result	Intervention
1.0 - 1.5	10% weekly increase of Warfarin or diet modification, INR within 2 weeks
1.6-1.9 treat if 2x in a row	10% weekly increase of Warfarin or diet modification, INR in 2 – 4 weeks
2.0 - 3.0	No intervention, INR in 4 weeks
3.1-3.5 treat if 2x in a row	10% weekly decrease of Warfarin or diet modification, INR in 2 – 4 weeks
3.6 - 4.0	10% weekly decrease of Warfarin or diet modification, INR in 2 – 4 weeks
4.1 - 4.9	Hold Warfarin 1 day & 10-20% weekly decrease of Warfarin beginning with the next dose, INR within 1-2 weeks via venous lab draw*
5.0 - 5.9	Hold Warfarin 2 days & 20% weekly decrease of Warfarin starting with next dose, consult with MD & determine next lab draw date*
6.0 - < 10	Hold Warfarin 2 days & 20% weekly decrease in Warfarin starting with next dose, INR within 1 week, consult with MD to determine next venous lab draw*
> 10	Physician evaluation before leaving clinic, lab draw*

High INR range desired (Target Range = 2.5 - 3.5)

INR Result	Intervention
1.0 - 1.5	20% weekly increase in Warfarin and consider diet modification, consider one additional 5 mg dose, INR within 1 week
1.6 - 2.0	20% weekly increase in Warfarin and/or diet modification, INR within 2 weeks
2.1-2.4, treat if 2x in a row	10% weekly increase in Warfarin or diet modification, INR in 2 – 4 weeks
2.5 - 3.5	No intervention, INR in 4 weeks
3.6-4.0, treat if 2x in a row	10% weekly decrease in Warfarin or diet modification, INR in 2 – 4 weeks
4.1 - 4.5	10% weekly decrease in Warfarin or diet modification, INR in 1-2 weeks, for venous lab draw.*
4.6 – 5.5	Hold Warfarin 1 day & 10% weekly decrease in Warfarin beginning with the next dose, INR within 1-2 weeks, for venous lab draw date* (If INR ≥ 5 consult with MD)
5.6 – 6.5	Hold Warfarin 1 day & 10% weekly decrease in Warfarin starting with the next dose, consult MD & determine next venous lab draw date*
6.6 - <10	Hold Warfarin 1-2 days & 20% weekly decrease in Warfarin starting with the next dose, consult with MD to determine next venous lab draw date*
>10	Physician evaluation before leaving clinic

[redacted]

Patient Identification Sticker
Goes Here

Warfarin (Coumadin®) Anticoagulation Reversal Orders

(The following orders are one-time orders for the current day.)

1. Current INR:_____ INR goal:_____
2. Check Protime/INR daily (if not already ordered) or as noted in the orders below.

☐ **Management of Over-Anticoagulation Without Bleeding**

INR	Risk Factors for Bleeding[1]	Thrombotic Risk[2]	Intervention (check box(es) desired)
Above target but less than 5	None Present or Present	Low or High	☐ No change; continue current warfarin dose. ☐ Hold warfarin today. ☐ Lower warfarin dose to ____mg po today
5 to 9	None Present	Low or High	☐ Hold warfarin today.
	Present	Low	☐ Hold warfarin & give Vitamin K ☐ 1.25mg OR ☐ 2.5mg orally
	Present	High	☐ Hold warfarin and monitor closely for bleeding ☐ Give Vitamin K ☐ 1.25mg or ☐ 2.5mg orally
Above 9	None Present	Low or High	☐ Hold warfarin & give Vitamin K 2.5mg orally
	Present	Low	☐ Hold warfarin & give Vitamin K 5mg orally
	Present	High	☐ Hold warfarin & give Vitamin K ☐ 2.5mg OR ☐ 5mg orally

1 and 2 (see back of form)

☐ **Management of Over-Anticoagulation With Bleeding**

Minor or Serious	INR	Intervention
Minor	Low or in target range	☐ No change in warfarin dose. Observe carefully for signs / symptoms of increased bleeding.
	Above target but < 5	☐ Lower warfarin dose to _____mg today; no Vitamin K
	5 to 9	☐ Hold warfarin & give Vitamin K ☐ 1.25mg OR ☐ 2.5mg orally
	Above 9	☐ Hold warfarin & give Vitamin K ☐ 2.5mg OR ☐ 5mg orally
Serious	Any INR	☐ Hold warfarin & give Vitamin K 10mg IV over 30 minutes, supplemented with 2 units of FFP. Recheck INR in 12 hours.

☐ **Reversal of INR for Emergent Invasive Procedures**

Surgical/Procedural risk of bleeding	INR	Intervention (In all cases, recheck INR in 12 hours and re-administer Vitamin K and /or FFP if needed.)
Moderate (Goal INR ≤ 1.5)	1.5 to in target range	☐ Hold warfarin & give Vitamin K 2.5mg orally. Consider FFP.
	Above target but < 5	☐ Hold warfarin, give Vitamin K 2.5mg orally, and 2 units of FFP.
	5-9	☐ Hold warfarin, give Vitamin K 5mg orally, and 2 units of FFP.
	> 9	☐ Hold warfarin, give Vitamin K 10mg orally, and 2 units of FFP.
High (Goal INR = 1)	Any INR	☐ Hold warfarin, give Vitamin K 10mg orally, and 2 units of FFP.

Physician Signature_____ Date_____ Time_____

[redacted]	Patient Identification Sticker Goes Here

1. Risk factors for bleeding:
   - History of GI bleeding (not peptic ulcer disease WITHOUT bleeding).
   - Hypertension
   - Cerebrovascular disease
   - Ischemic Stroke
   - Heart Failure
   - Renal Insufficiency
   - Concurrent aspirin and/or clopidogrel (Plavix®)
   - Age greater than 75 years
   - Recent major surgery

2. Thrombotic Risk
   - A. Low Thrombotic Risk
     - i. Atrial fibrillation WITHOUT:
       - a. history of severe left ventricular dysfunction (ejection fraction less than 25%)
       - b. clinically significant rheumatic heart disease
       - c. previous thrombembolic events within the past 6 months
       - d. cardioversion in the last month
       - e. bioprosthetic heart valve
       - f. severe left atrial enlargement
     - ii. More than one month since arterial thromboembolism
     - iii. Deep vein thrombosis (DVT) prophylaxis
     - iv. More than 3 months since DVT or pulmonary embolism
   - B. High Thrombotic Risk
     - i. Atrial fibrillation WITH:
       - a. history of severe left ventricular dysfunction (ejection fraction less than 25%)
       - b. clinically significant rheumatic heart disease
       - c. previous thrombembolic events within the past 6 months
       - d. cardioversion in the last month
       - e. bioprosthetic heart valve
       - f. severe left atrial enlargement
     - ii. Less than one month since arterial thromboembolism
     - iii. Mechanical heart valves
     - iv. Less than 3 months since DVT or pulmonary embolism

References:
Gulseth PharmD, Michael. Managing Anticoagulation Patients in the Hospital. 2007: 58-61.
American College of Chest Physicians. Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). CHEST 2008; 133:174S-176S

Re: Change in ACCP Guidelines for Vitamin K Administration

Dear LivingCenter and AseraCare Medical Directors,

The American College of Chest Physicians (ACCP) has released their evidence-based guidelines on the management of warfarin therapy, including when evidence supports administration of vitamin K.

- The ACCP no longer recommends administering vitamin K for INRs between 4.5 and 10 if there is no evidence of bleeding. Instead, the ACCP recommends holding 1 – 2 doses of warfarin and restarting therapy at a lower dose. The basis of the recommendation is that while administration of vitamin K to patients with INRs between 4.5 and 10 rapidly lowers the INR, there are no measureable differences in the percentage of patients who bleed with or without vitamin K administration.
- Oral vitamin K is recommended in patients taking warfarin when the INR value is greater than 10 and there is no evidence of bleeding. Oral administration is predictably effective, safer and more convenient than parenteral routes and is the route of choice. Revised CHEST guidelines (2012) recommend the use of 2.5mg (1/2 tablet).
- For patients with major bleeding associated with warfarin, ACCP recommends administration of four factor prothrombin complex concentrate (PCC) in conjunction with vitamin K 5 – 10 mg administration by slow IV injection. (Vitamin K administered by IV injection may be associated with anaphylactic reactions; the rate of infusion should not exceed 1mg/min. While often used in the past, subcutaneous vitamin K absorption may be delayed and unpredictable and is not recommended.)

A revised INR management table is provided below.

INR	Management
Greater than 4.5, but less than 10 (>4. 5 but < 10) No significant bleeding	§ Withhold warfarin and monitor INR more frequently (daily) and for signs and symptoms of bleeding and resume therapy at lower dose once INR returns to therapeutic range § Routine use of Vitamin K is not recommended
Greater than 10 (>10) No significant bleeding	§ Hold warfarin therapy and administer vitamin K 2.5mg orally (1/2 of 5mg tablet) and expect substantial INR reduction in 24-48 hours. § Monitor INR more frequently (daily) and administer additional vitamin K 2.5mg orally if no substantial INR reduction in 24-248 hours. § Resume therapy at lower dose once INR returns to therapeutic range.
Major bleeding	§ Discontinue warfarin and administer four-factor prothrombin complex concentrate rather than plasma. Also, administer vitamin K 5-10 mg slow IV infusion; repeat as necessary q4-6 hours.

Reference: Holbrook A, et al. Evidence-based management of anticoagulant therapy: antithrombotic therapy and prevention of thrombosis, 9th ed: ACCP Evidence-based Clinical Practice Guidelines. Chest 2012;141;e152S-e184S.

Asthma Action Plan

DATE: _____ /_____ /_____ PATIENT NAME _____

WEIGHT: _____ EMERGENCY CONTACT _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: _____ /_____ /_____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber / spacer** **with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE — DOING WELL — GO!

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work/exercise easily
- Sleeping all night

Peak Flow is between: _____ **and** _____

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

YELLOW ZONE — GETTING WORSE — CAUTION

You have ANY of these:

- Difficulty breathing
- Coughing
- Wheezing
- Tightness in chest
- Difficult to work/exercise
- Wake at night coughing

Peak Flow is between: _____ **and** _____

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE** **more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have ANY of these:

- It's very hard to breathe
- Nostrils open wide
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: _____ **and** _____

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR** CALL **911** immediately.

DATE: _____ /_____ /_____ MD/NP/PA SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

Asthma Action Plan

DATE: _____ /_____ /_____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: _____ /_____ /_____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE — DOING WELL — GO!

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

Peak Flow is between: _____ **and** _____

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

YELLOW ZONE — GETTING WORSE — CAUTION

You have ANY of these:

- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

Peak Flow is between: _____ **and** _____

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE** **more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have ANY of these:

- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: _____ **and** _____

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR** CALL **911** immediately.

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: _____ /_____ /_____ MD/NP/PA SIGNATURE _____

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable)*.

DATE: _____ /_____ /_____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

[redacted]

Patient Identification Sticker
Goes Here

Pneumonia – Adult

Admit to: ❑ Med/Surg *or* ❑ ICU
- ❑ Vital signs QID with pulse oximetry
- ❑ Oxygen @ _____ liters per nasal catheter, titrate to keep sats ≥ 90%
- ❑ CBC and BMP Now and in AM
- ❑ Saline lock with routine care
- ❑ STAT blood cultures x 2
- ❑ Arterial blood gases
- ❑ STAT sputum gram stain and culture if productive cough present.
- ❑ IV of _____ @ _____ mL/hr
- ❑ PA and lateral chest x-ray ☐ Now ☐ and in AM
- ❑ Smoking cessation counseling, if patient is a smoker.
- ❑ I & O for 48 hours
- ❑ Force fluids to 2000 mL ☐ Yes ☐ No ☐ Fluid restriction of _____
- ❑ Activity: up in chair 1st day, then ambulate TID as tolerated
- ❑ Implement Pneumovax and Influenza standing orders
- ❑ Pneumo urinary antigen test

Healthcare Associated Pneumonia (HCAP) Risk Factors *(check all that apply)*:
- ❑ Hospitalization ≥ 2 days in previous 90 days (do not have to be consecutive)
- ❑ Residence in a nursing home for any amount of time in the last 90 days
- ❑ Home infusion therapy (including antibiotics)
- ❑ Chronic dialysis within 30 days
- ❑ Wound care provided by a healthcare provider within the last 30 days

***Pseudomonas* Risk Factors** *(check all that apply)*:
- ❑ Bronchiectasis documented as a possible consideration at time of admission
- ❑ COPD and history of repeated courses of antibiotics and/or corticosteroids
- ❑ Other: _____

MRSA Risk Factors *(check all that apply)*:
- ❑ Lung abscess
- ❑ Recent influenza infection
- ❑ Injection drug user
- ❑ History of MRSA infection

Compromised Risk Factors:
- ❑ Immunocompromised
- ❑ On chronic systemic steroids
- ❑ Previous hospitalization within 14 days

Antibiotics: Start **ASAP** after blood cultures drawn, and preferably after sputum culture is obtained.

Community-Acquired: Non-ICU Admit, No Risk Factors	Community-Acquired: ICU Admit, No Risk Factors	Community-Acquired: *Pseudomonas* Risk Factors	Community-Acquired: MRSA Risk Factors	HCAP Risk Factors: *Without additional risk factors*	HCAP Risk Factors: *With additional risk factors*	Aspiration Pneumonia
❑ **Ceftriaxone** 1 gm IV q24h AND **Azithromycin** 500 mg IV q24h	❑ **Ceftriaxone** 2 gm IV q24h AND **Azithromycin** 500 mg IV q24h	❑ **Zosyn**† 4.5 gm IV q6h AND **Levofloxacin**† 750 mg IV q24h	**Select one regimen from column 1, 2, OR 3, and ADD the following**	❑ **Ceftriaxone** 2 gm IV q24h AND **Azithromycin** 500 mg IV q24h	**Select one regimen from column 3 and, if MRSA risk, from column 4**	❑ Community Acquired/ Healthcare Associated **Levofloxacin**† 750 mg IV q24h
❑ **Levofloxacin**† 750 mg IV q24h	❑ **Ceftriaxone** 2 gm IV q24h AND **Levofloxacin**† 750 mg IV q24h	❑ *Beta-lactam allergic:* **Aztreonam**† 2 gm IV q8h AND **Levofloxacin**† 750 mg IV q24h	❑ **Vancomycin**† 20 mg/kg (max of 2gm) =_____mg IV x 1, then pharmacist to dose	❑ **Ceftriaxone** 2 gm IV q24h AND **Levofloxacin**† 750 mg IV q24h		❑ Severe periodontal disease, putrid sputum, or alcoholism **Zosyn**† 3.375gm IV q6h **OR** *(see box below)*
	❑ *Beta-lactam allergic:* **Levofloxacin**† 750 mg IV q24h AND **Aztreonam**† 2 gm IV q8h	❑ If recently received a fluoroquinolone, add **Gentamicin**† IV (see H00472). Pharmacist to follow & dose.		❑ *Beta-lactam allergic:* **Levofloxacin**† 750 mg IV q24h AND **Aztreonam**† 2 gm IV q8h		❑ **Ceftriaxone** 1 gm IV q24h AND **Clindamycin** 600 mg IV q8h

Other Medication Orders:
- ❑ **Ipratropium 0.5 mg/ Albuterol 2.5 mg (Duoneb)** nebulizer every ___ hrs ☐ scheduled OR ☐ PRN
- ❑ **Albuterol 2.5 mg unit dose** nebulizer treatment every ____ hrs ☐ scheduled OR ☐ PRN
- ❑ Adult Severe Obstructive Lung Disease Neb Orders H00069
- ❑ **Acetaminophen 650 mg** PO/PR q4h PRN pain or temp > _____°F
- ❑ **Pharmacist to adjust antibiotic dosing per renal function**†

Physician Signature_____ **Date**_____ **Time**_____

[redacted]

Patient Identification Sticker
Goes Here

ADULT SEVERE OBSTRUCTIVE LUNG DISEASE NEBULIZER ORDERS

DATE/TIME NOTED

1. Start with Albuterol 2.5mg/3ml Neb. ASAP (This treatment serves as time zero.) — Starting time: time zero _____
2. Time: 30 minutes — Albuterol 2.5mg unit dose via nebulizer
3. Time: 1 hour — Albuterol/Ipratropium 0.5 mg/3 ml (Duoneb) via nebulizer
4. Time: 2 hours — Unit dose Albuterol 2.5 mg/3 ml via nebulizer

From this point, nebs are given every three (3) hours in the following sequence.

5. Duoneb
6. Unit dose Albuterol
7. Duoneb
8. Unit dose Albuterol
9. Continue this sequence, one nebulizer treatment every three hours, until the order is re-written.

_____ _____

Signature Date / Time

[redacted]

Patient Identification Sticker
Goes Here

ADULT POTASSIUM CHLORIDE REPLACEMENT STANDING ORDERS

Check box for route of administration desired.

☐ **ORAL ROUTE OF ADMINISTRATION**
(preferred route due to safety issues with IV potassium administration)

DATE/TIME | **NOTED**

Serum K^+ less than 3.0 mEq/L

1. Oral KCL solution 20 mEq mixed with 4 ounces of water or juice q 2 hours x 4 doses.
2. Recheck serum K^+ 2 hours after last dose. If K^+ is less than 3.6, contact the physician.
3. Repeat serum K^+ the next a.m.

Serum K^+ 3.0 to 3.5 mEq/L

1. Oral KCL solution 20 mEq mixed with 4 ounces of water or juice q 2 hours x 2 doses.
2. Recheck serum K^+ 2 hours after last dose. If K^+ is less than 3.6, contact the physician.
3. Repeat serum K^+ the next a.m.

☐ **INTRAVENOUS ROUTE OF ADMINISTRATION**

DATE/TIME | **NOTED**

Serum K^+ less than 3.0 mEq/L

1. KCL 10 mEq IV over 60 minutes every 1 hour x 6 doses.
2. Recheck serum K^+ 1 hour after last dose. If K^+ is less than 3.6, contact the physician.
3. Repeat serum K^+ the next a.m.
4. Pharmacy to add 10 mg lidocaine to each bag if patient has a peripheral line and does not have an allergy to lidocaine.
5. Telemetry

Serum K^+ 3.0 to 3.5 mEq/L

1. KCL 10 mEq IV over 60 minutes every 1 hour x 4 doses.
2. Recheck serum K^+ 1 hour after last dose. If K^+ is less than 3.6, contact the physician.
3. Repeat serum K^+ the next a.m.
4. Pharmacy to add 10 mg lidocaine to each bag if patient has a peripheral line and does not have an allergy to lidocaine.

_____ _____

Signature Date/Time

[redacted]

Patient Identification Sticker
Goes Here

ADULT MAGNESIUM REPLACEMENT STANDING ORDERS

Check box for route of administration desired and medication desired, as applicable.

☐ **ORAL ROUTE OF ADMINISTRATION**
(only to be used for mild hypomagnesemia with serum magnesium of 1.3-1.5mg/dL)

DATE	NOTED

1. Medication (Check one box)
   - ☐ Magnesium Oxide (MagOx®) 400mg tablet (equivalent to 240mg elemental magnesium per tablet), one tablet orally three times daily
   - ☐ Magnesium hydroxide (MOM) suspension 400mg/5ml (equivalent to 167mg elemental magnesium per 5ml), one teaspoonful = 5ml orally four times daily
2. Serum magnesium level on _____

☐ **INTRAVENOUS ROUTE OF ADMINISTRATION**

DATE	NOTED

Serum Magnesium 1.3 to 1.5 mg/dL

1. Magnesium Sulfate 2 grams IV over 2 hours x 1 dose.
2. Serum magnesium level the next a.m.

Serum Magnesium 1 to 1.29 mg/dL

1. Magnesium Sulfate 2 grams IV over 2 hours q6h x 2 doses.
2. Serum magnesium the next a.m.

Serum Magnesium Less Than 1 mg/dL (asymptomatic)

1. Magnesium Sulfate 4 grams IV over 4 hours x 1 dose.
2. Magnesium level 4 hours after completion of IV infusion. Contact MD if magnesium level less than 1.5 mg/dL.
3. Repeat magnesium level the next a.m.

Serum Magnesium Less Than 1 mg/dL (symptomatic)

1. Magnesium Sulfate 2 grams IV over 15 minutes, then 4 grams IV over 4 hours x 1 dose.
2. Magnesium level 4 hours after completion of infusion. Contact MD if magnesium level less than 1.5 mg/dL.
3. Repeat serum magnesium level the next a.m

_____, M.D. _____
Signature Date/Time

[redacted]

Patient Identification Sticker
Goes Here

ADULT ALCOHOL WITHDRAWAL SYNDROME STANDING ORDERS

1. Valium (Diazepam) and Ativan (Lorazepam) may not be administered to the following patients without a specific MD order:
   A. Systolic BP < 100
   B. RR < 12
   C. Shallow respirations or signs of upper airway obstruction.
   D. Patient difficult to arouse.

2. Complete Multi System Severity Assessment (MSSA) scale and vital signs: Repeat per following guidelines

MSSA Score	Repeat MSSA & Vital Signs
< 8	4 hours
<8 x 2	8 hours
8-14	2-4 hours
15-19	1 hour
>20	30 minutes

3. * Administer Ativan (lorazepam) IV after each MSSA using the following guidelines:

MSSA Scale Score	Ativan (Lorazepam)	
<8	0	* **(may administer lorazepam orally at nurses' discretion)**
8-19	1-2 mg	
>20	2-4 mg	

4. If MSSA >20 and patient not responding to Ativan (Lorazepam), use Valium (Diazepam) IV per dosage guideline **after contacting physician:**

MSSA Scale Score	Valium (Diazepam)
<8	0
8-19	5-10 mg
>20	10-20 mg

5. Tenormin (Atenolol) 50 mg PO daily. Hold if HR < 50 and/or history of asthma or CHF.

6. If more than 10 mg of Ativan (Lorazepam) is used in 24 hours and MSSA < 8 – put patient on tapering Ativan (lorazepam) schedule reducing each day's dose by 50%. ***Contact MD for specific order.***

7. Thiamine 100mg PO or IV daily x 3 days. Give before receiving any glucose.

8. Folic acid 1 mg PO or IV daily through discharge.

9. Call physician for seizure activity; suicidal tendencies; need for increased lorazepam schedule.

10. Should signs of benzodiazepine overdose or toxicity develop such as CNS depression, respiratory depression (RR <12 and/or shallow respirations, decreasing SPo2), increased lethargy/difficult to arouse, may give:
    - flumazenil (Romazicon) 0.2mg IVP over 15 seconds. If patient does not reach desired level of consciousness within 45 seconds, may repeat dose one time. ***Contact MD for further orders.***

_____ _____

Physician Signature Date/Time

Altering Insulin dosing

Ensuring consistent dosing of insulin is important in the overall care of the patient. It decreases episodes of hyperglycemia and hypoglycemia and studies have shown significant decrease in mortality and morbidity associated with improved control of blood sugars.

Administering a different dose

- A decreased dose of Insulin should be considered if blood sugar (BS) is low (<100) or high (>300).
- If BS<70, Insulin should be held until after discussion with provider (follow hypoglycemic/Insulin protocol)
- If BS>350, should discuss with provider possible additional Insulin.
- If BS consistently (more than 6x/week) >250, BS should be reviewed by provider when next on-site.

Different timing of dose

- If patient does not receive Insulin within 1 hour either before or after a meal, it should be held until the next dose.
- If patient is out of the building and then returns and is given a meal, Insulin should be administered within 30 minutes of eating, unless the next dose of Insulin is within 4 hours, then discuss with provider

Holding Insulin

- If patient is not eating and has BS<110 short acting insulin should be held, if BS is consistently less than 100 then provider should be notified during next rounding day to make adjustments in long acting Insulin.

LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

UNSTAGEABLE, DISEASE & TRAUMA WOUNDS	PRODUCT TYPES & CATEGORIES (9)	PRODUCT BRANDS & OPTIONS (18)	PRODUCT PHOTOS
START STANDARD DOs w **PREVENTION BASICS** **STANDING ORDERS:** If awaiting Physician/NP treatment orders, use the following **STANDARD SOP** until order is obtained. **DIABETIC WOUNDS SOP:** 1) Cleanse w sterile water or peri-wash 2) Fill wound depth with SILVRSTAT** 3) Cover with transparent film* or Hydrocolloid* Change **q3** days ***IF DRAINING*** **3b)** Cover with foam and change **QD** **BURNS SOP:** 1) Relieve pressure (pillow, prop, fluidized mattress etc.) 2) Irrigate burn are with sterile water 3) Apply SILVRSTAT to burn area 4) Cover entire area with moist dressings ***OR*** sterile gauze dampened with SILVRSTAT 5) Assess pain level, administer pain meds PRN 6) Change **q3** ***IF DRAINING*** **6b)** change dressings **QD** **ARTERIAL WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Change **q3** days ***IF* DRAINING** **6b)** change dressings **QD** **VENOUS WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Elevate leg as long as tolerated by patient **BID** 7) Change **q3** days ***IF DRAINING*** **7b)** change dressings **QD**	**WOUND CLEANSING** **Irrigation/Peri-wash**	**Sterile Water (B BRAUN); Peri-Wash (Convatech)**	
	TRANSPARENT FILM	**Tegaderm Transparent Dressing (3M); OpSite (Smith & Nephew)**	
	HYDROGEL	**SILVRSTAT** (ABL Medical)**	
	HYDROCOLLOID	**Tegaderm Hydrocolloid Thin (3M); DuoDERM Extra Thin (Convatec)**	
	FOAM	**Allevyn Non-adhesive or Allevyn Adhesive (Smith & Nephew); Tegaderm Foam Adhesive (Smith & Nephew)**	
	CALCIUM ALGINATE	**Sorbsan (Mylan-Bertek); Algisite M (Smith & Nephew)**	
	COVER DRESSINGS	**Tegaderm+Pad (3M);Non-Adherant Pads (Kendall); Telfa Island Dressing (Kendall)**	
	BARRIER OINTMENTS	**Calmoseptine; Cavilon (3M)**	
	SKIN SEALANT	**Cavilon (3M); Skin Prep (Smith & Nephew)**	

LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

PREVENTION BASICS

DO:

- Complete Braden & Comprehensive Assessment
- Reposition ***at-risk residents*** per individual sitting and lying intervals
- Daily skin inspections with cares
- Weekly skin inspections by LPN or RN include measurements
- Minimize exposure to moisture (incontinence, perspiration, drainage etc.)
- Moisturize dry skin
- Minimize shear and friction through (proper positioning, transferring & turning techniques, protective dressings, skin sealants or corn starch)
- Use moisture barriers
- Consult with Dietary and Therapy departments to enhance care continuity
- Pay attention to nutrition & hydration
- Facilitate mobility through activity, ROM exercises and positioning
- Use pressure reduction devices in bed, chair and wheelchair
- Use positioning devices to pad bony prominences
- Relieve heel pressure in bed
- Maintain HOB at lowest possible elevation
- Use lifting devices
- Involve/educate resident, family and staff in PREVENTION BASICS.

DO NOT

- Use hot water
- Use donut-type devices
- Massage skin over bony Prominence

STAGE 1 or DEEP TISSUE INJURY (Intact Skin)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP topical treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 1 SOP:

1) Monitor area
2) Protect skin from moisture/incontinence with barrier ointment

TOPICAL & DRESSING SUPPLIES (see back of card for clinic/facility specific brands)

***DO NOT use Hydrocolloid dressings or transparent films on infected wounds.**

****DO USE SILVRSTAT gel in place of Hydrogel whenever infection is possible, suspected or present.**

(See STANDING ORDERS for ARTERIAL and VENOUS WOUNDS on back of card.)

STAGE 2 (Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 2 SOP:

1) Cleanse with sterile water or peri-wash initially & at each dressing change
2) Protect peri-wound (skin sealant/barrier)

NO DRAINAGE

3) Apply SILVRSTAT** to wound base **q3** days with cover dressing
   OR
   3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING

4) Apply adhesive foam **QD**
   OR
   4b) If wound has depth loosely fill with lightly moist sterile gauze and cover dressing QD

STAGE 3 & 4 (Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following **SOP** until order is obtained.

STAGE 3 & 4 SOP:

1) Cleanse with sterile water initially & at each dressing change
2) Protect peri-wound (skin sealant/barrier)

NO DRAINAGE

3) Apply SILVRSTAT** to wound base **QD** with cover dressing
   OR
   3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING

4) Apply adhesive foam **QD**
   OR
   4b) If wound has depth <u>layer Calcium Alginate in or over</u> slough area before applying SILVRSTAT, loosely fill with lightly moist sterile gauze and cover apply cover dressing QD

UNSTAGEABLE, DISEASE & TRAUMA WOUNDS

***DEFINITION*: UNSTAGEABLE WOUNDS are all wounds that are covered by Eschar or slough or caused by disease trauma/BURNS.**

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders, use the following **SOP** until order is obtained.

INTACT BLACK HEEL SOP:

1) Relieve pressure (pillow, prop etc.)
2) Leave intact unless S/S of infection
3) Cover with DRY gauze

MACERATION/ EXCORIATION/EDEMA SOP:

1) Cleanse w sterile water or peri-wash
2) Apply barrier ointment following each episode of incontinence
3) <u>If edema is suspected cause</u> call physician immediately

SKIN TEARS SOP:

1) Cleanse w sterile water or peri-wash
2) Apply thin layer SILVRSTAT** let dry ***BEFORE***
3) Appling Steri Strips or cover with transparent film*. Change **q5** days or PRN for dislodgement or leakage

[redacted]

BEST PRACTICE GUIDELINES FOR WOUND CARE

SUSPECTED DEEP TISSUE	STAGE I	STAGE II	STAGE III & IV	UNSTAGEABLE	DIABETIC ULCERS	ARTERIAL ULCERS	VENOUS INSUFFICIENT ULCER
Treatment may include:	Treatment may include:	Light Drainage	Dry Wound:	Treatment may include:	Dry Wound:	Dry Wound:	Dry Wound:
Apply *Barrier cream* to buttocks with each episode of incontinence. Or *Apply Topical Skin Protectant* to reddened area qd for protection Or *Apply Topical Skin Protectant* to periwound area and cover with *Transparent dressing* Q 7 days and PRN for dislodgement	*Apply Barrier cream* to buttocks with each episode of incontinence. Or *Apply Topical Skin Protectant* to reddened area qd for protection Or *Apply Topical Skin Protectant* to periwound area and cover with *Transparent dressing* Q 7 days and PRN for dislodgement	Cleanse with normal saline and apply *Barrier cream* to buttocks with each episode of incontinence. Or *Apply Topical Skin Protectant* to periwound skin and *Apply Gel*, cover with appropriate secondary dressing • Foam Or *Apply hydrocolloid* May frame with tape to prevent premature dislodgement Change q 3 days and PRN for dislodgement, leakage and/or according to manufacturers recommendation	Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin *Apply Gel*, cover with appropriate secondary dressing Or Draining Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Line wound bed with *Calcium Alginate* (rope or sheet) - fill remaining space gauze Cover with an *Absorptive* dressing • Foam May frame with tape to prevent premature dislodgement Change q 3 days and PRN for dislodgement, leakage and/or according to manufacturers recommendation	Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin *Apply Gel* or *hydrocolloid* for autolytic debridement Cover with appropriate *secondary* dressing Change q 3 days and PRN for dislodgement, leakage and/or according to manufacturers recommendation Or *Apply chemical debriding agent* if 100% of wound bed is necrotic for chemical debridement Cover with gauze and change q day. (Do not cover with occlusive dressing) Discontinue chemical debridement when necrotic tissue is dissolved. Continue with moist wound healing Intact Black Heel: Relieve pressure No dressing No debridement	Dry Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin *Apply Gel*, cover with appropriate secondary dressing Or Draining Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Line wound bed with *Calcium Alginate* (rope or sheet) - fill remaining space with gauze Cover with an *Absorptive* dressing Change of 3 days & PRN for dislodgement, leakage and/or according to manufacturers recommendation	Dry Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Apply *Gel*, cover with appropriate secondary dressing Or *Apply hydrocolloid* May frame with tape to prevent premature dislodgement Or Draining Wound Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Line wound bed with *Calcium Alginate* (rope or sheet) - fill remaining space with gauze Cover with an *Absorptive* dressing Change of 3 days & PRN for dislodgement, leakage and/or according to manufacturers recommendation	Dry Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Apply *Gel*, cover with appropriate secondary dressing • Foam dressing Or Draining Wound: Cleanse with normal saline *Apply Topical Skin Protectant* to periwound skin Line wound bed with *Calcium Alginate* (rope or sheet) - fill remaining space with gauze Cover with an *Absorptive* dressing Change of 3 days & PRN for dislodgement, leakage and/or according to manufacturers recommendation

Patient name/Sticker

_____

Room: DOB:

Standing House and Protocol Check list Order

- ☐ **Standing House Orders**
- ☐ **Blood Sugar Management Protocol**
- ☐ **Bowel protocol**
- ☐ **Bladder Management Protocol**
- ☐ **IV Line Management Protocol**
- ☐ **After Hours INR Coverage Protocol**
- ☐ **Wound Care Protocol**

Provider Signature:_____ Date:_____

Nurse Review___ (Initials)

STANDING ORDERS for TRANSITIONAL CARE

The following standing orders are applicable for patients of medical teams in designated transitional care centers. These orders are to be used instead of facility standing orders. When any standing orders are initiated by facility staff, results are to be communicated to the NP/MD the next working day.
Discontinue standing house orders from previous facility
After business hours and all day on weekends and holidays, contact the on-call staff with:

1) Critical patient care issues that need to be addressed prior to the next NP/MD visit
2) Clarification of admission orders that represent critical concerns

Otherwise contact the primary care team on the next business day

Admission to Facility

- Initial vitals, including height and weight documented in the chart
- Daily vital signs (TPR, BP and O2saturation) for 3 days
- Weekly weights for patients without CHF unless directed
- For patients with CHF
- Daily weights
- Call for weight gain >2.5# in 48 hours or 5 # above admission weight
    - Assess lung sounds, peripheral edema, and respiratory effort daily
- Physical therapy, Occupational therapy and/or Speech therapy to evaluate and treat as indicated
- Administer facility mental status testing and PHQ9 section of the MDS.
- Administer two-step Mantoux unless history of TB or positive PPD.
- If PPD has been positive or contraindicated, a negative chest x-ray within three months in advance of admission or within 72 hours after admission is required. Call results to NP/MD next business day unless results are abnormal. Obtain copy of CXR report to document “active TB negative” status.
- Per CDC guidelines may administer influenza vaccine to patients who have not already received it unless contraindicated (i.e., temp> 100° F, allergy to eggs or influenza vaccine)
- Per CDC guidelines may administer Pneunovax to patients that have not already received it unless contraindicated.

Diet

- When specific diet orders are not present, the nurse or dietitian may initiate a diet that conforms to the facility's dietary options and best meets the patient's needs
- 2 Gm sodium diet for all admissions with CHF as an active diagnosis
- May change diet to house equivalent
- If patient has a feeding tube, administer 150 ml free water q 8 hours via feeding tube unless directed otherwise

Medications

Initiate self-administration of medication (SAM) evaluation when there is a question regarding the patient's ability to self-administer meds; include Lovenox, insulin and blood glucose

Patient may keep multi-dose inhalers, nitroglycerin tablets and eye drops at bedside for SAM after patient demonstrates ability to safely self-administer the specific medication.

Comfort

- Acetaminophen 650 mg Q 4 hours PRN pain
  - (not fever – call NP/MD for all new fever episodes)
  - All patients -acetaminophen not to exceed 3 grams per 24 hours regardless of admission orders
- Cepacol (or therapeutic equivalent) (regular or sugar free) 1 lozenge dissolved in mouth q 2 hours PRN for sore throat
- Apply ice for 20 min qid PRN to injuries with inflammation
- Preparation H or Anusol ointment (or therapeutic equivalent) per package instructions PRN after bowel movement for hemorrhoid pain
- Lidocaine 1% 1.8 ml as a diluent with IM Rocephin PRN for local anesthesia

Respiratory

- Guaifenesin (plain) 2 tsp PO q 6 hours PRN for upper respiratory symptoms (expectorant) Albuterol 2.5 mg NEB x one dose PRN for dyspnea or wheezing **AND call NP/MD with a nursing assessment**
- O2 via nasal cannula 1-4 L per minute PRN for dyspnea, hypoxia (02 saturation <88%) or acute angina **AND call NP/MD with a nursing assessment**
- May initiate O2 weaning per nursing judgment to keep O2 sats >88%; monitor O2 saturations q shift X 3 days after oxygen is discontinued, including one O2 saturation during night-time sleep In patients with a tracheostomy, initiate trach care per facility protocol, suction PRN, and use a trach dome when O2 is indicated

Cardiovascular

- Nitroglycerin 0.4 mg SL PRN for chest pain or other signs/symptoms of acute angina; may repeat q 5 minutes x 2
- If chest pain/acute angina is not relieved after two doses of nitroglycerin, call 911 unless contrary to advanced directives; notify NP/MD immediately.

Indigestion

- Antacid (facility stock) 30 ml PO qid PRN

Note -magnesium-based products are contraindicated for renal patients Tums (or therapeutic equivalent) 500 mg 1 tab PO (chewable) qid PRN

Sleep

- Institute 3 day sleep record by nursing staff

Cerumen

- Debrox or mineral oil 3 drops to affected ear bid x 3 days
- Gently irrigate affected ear canal with tepid H20 on 4th day
- Repeat x I if indicated and update NP/MD

MD/NP provider _____

Blood Sugar Management Protocol

- Initiate meal time and bedtime blood glucose (BG) monitoring upon admission X 7 days for ALL diabetic patients unless admitting orders specify otherwise
- Notify NP/MD if two blood glucose results are < 70 or > 400 in a 24 hr period and/or condition change. If no condition change notify during next business day.
- If not specified: no coverage with insulin at HS

Hyperglycemia (BG > 200)

- Administer NovoLog insulin < 15 minutes before the meal due to rapid onset of action Use the following sliding scale when a sliding scale is ordered but dose is not specified.

Blood glucose	> 450	12 units subcutaneously (sc)
Blood glucose	400 -450	10 units sc
Blood glucose	350 -399	8 units sc
Blood glucose	300 -349	6 units sc
Blood glucose	250 -299	4 units sc
Blood glucose	200 -249	2 units sc
Blood glucose	< 200	0 units

Hypoglycemia (BS < 70)

- If patient is symptomatic, conscious, and able to swallow or has a feeding tube:
- Administer 6 oz. fruit juice, milk, regular pop, or other high carbohydrate beverage (i.e., Ensure, Boost) orally or via feeding tube
- Repeat BG after 10 minutes; if < 70, repeat above intervention
- Repeat BG again in 10 minutes; if< 70 and equipment is determined to be functioning accurately, administer tube of Glucose Gel
- If BG remains < 70 on a fourth test, notify NPIMD
- If patient is unresponsive or unable to swallow and does not have a feeding tube: ○ Administer Glucagon 1 mg IM
- Repeat BG after 10 minutes; if < 70 and patient still unresponsive, repeat Glucagon and notify NP/MD immediately.
- Call 911 while waiting for NP/MD response.
- If BG remains < 70 but patient is conscious, initiate interventions for the conscious patient
- Communicate occurrence of any hypoglycemic event to NP/MD the next working day

MD/NP provider _____

Bowel Management Protocol

Bowel: Diarrhea

- Perform rectal check for impaction
- If impacted follow guidelines for constipation If not impacted:
- Stop all cathartic (constipation) related meds and observe If diarrhea continues:
  - Send stool specimen for C. diff toxin A and B
  - Initiate clear liquid diet for 24 hours
  - Notify NP/MD of the change in condition

Bowel: Constipation

- Perform rectal check for impaction
- Encourage 2,000 ml daily fluid intake unless contraindicated Dietary to initiate high fiber diet or supplements
- Order: Senna S 1 tab po bid prn
- If no BM x 1 day then schedule Senna S 1 tab po bid
- If no BM x 2 days start Miralax 17gm po q d
- If no BM x 3 days then Bisacodyl suppository 10 mg PR every 3 days PRN
- Fleets enema PR every 3 days PRN if no results from suppository, do not use in renal failure or renal insufficiency)

MD/NP provider _____

Bladder Management Protocol

- Discontinue urinary catheter unless the admitting H & P indicates a diagnosis of neurogenic bladder, prostate hypertrophy with obstruction or urinary retention. If placed for wound management call before removing.
- After removing the catheter:
  - Assess voiding q 6 h with bladder scan or history
  - If PVR is > 250 cc on scan, no voiding in 6 hours, nursing assessment by palpation of full bladder, or patient uncomfortable: straight catheter
  - Ok to use lidocaine jelly 2% catheter lubricant
  - Continue striaght catheter q 6 hrs until patient voiding spontaneously

- **Care of the indwelling catheter**
  - Do not irrigate
  - Change chronic catheter q month, use same catheter and balloon size that patient has had placed previously
  - Change catheter bag q week
  - Change PRN for leaking or decreased urinary output with similar sized catheter Change catheter and tubing prior to obtaining a UA/UC
  - Ensure bag is not touching the flow
  - May attach leg bag when patient is up, reattach straight drainage when in bed

MD/NP provider _____

IV Line Management Protocol

- Initiate routine IV line and site care per facility protocol
- May replace peripheral line per facility protocol or pm for site infiltration or phlebitis
- May DC PIV site if no indication for use. DO NOT remove PICC or central lines without consulting MD/NP.

- PICC line to be used for all antibiotics greater than 5 days
- PICC line insertion by IV team
- CXR for placement
- Once placement confirmed by IV nurse or provider may use for infusion
- OK to use PICC line for blood draws
- Flushes per Omnicare IV protocol

MD/NP provider _____

After Hours INR Coverage

.

WEEKENDS and AFTER 5:00 PM INR Protocol
Coumadin Management-DVT or PE or CVA or A fib
INR Goal 2.0-3.0

INR <2.0 Call on-call for further directions

INR 2.0-3.0 Give same Coumadin dose-Notify primary MD/NP for further INR/Coumadin orders.

INR 3.0-5.0 Hold dose of Coumadin-Check INR in AM, call primary MD/NP with results (on-call staff if primary MD/NP is not available) for INR/Coumadin orders.

INR >5 Call on-call staff for further directions.

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

WEEKEND and AFTER 5:00 PM INR Protocol
Coumadin Management-Joint Replacement Prophylaxis
INR Goal 1.8-2.5

INR <1.8 Call on-call staff for further directions

INR 1.8-2.5 Give same Coumadin dose-Notify primary MD/NP in the AM (on-call staff if primary MD/NP not available) for further INR/Coumadin orders.

INR 2.5-5.0 Hold dose of Coumadin-Check INR in AM, contact primary MD/NP with results (on-call staff if MD/NP not available) for INR/Coumadin orders

INR >5.0 Call on call staff for further directions

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

WEEKEND and AFTER 5:00 PM INR Protocol
Coumadin Management-Mechanical Heart Valve
INR Goal 2.5-3.5

INR <2.5 Call on-call staff for further directions

INR 2.5-3.5 Give same Coumadin dose-Notify primary MD/NP in the AM (on-call staff if primary MD/NP not available) for further INR/Coumadin orders.

INR 3.5-5.0 Hold dose of Coumadin-Check INR in AM, contact primary MD/NP with results (on-call staff if MD/NP not available) for INR/Coumadin orders.

INR >5.0 Call on-call staff for further directions

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

MD/NP provider _____

LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

PREVENTION BASICS

DO:

- Complete Braden & Comprehensive Assessment
- Reposition ***at-risk residents*** per individual sitting and lying intervals
- Daily skin inspections with cares
- Weekly skin inspections by LPN or RN include measurements
- Minimize exposure to moisture (incontinence, perspiration, drainage etc.)
- Moisturize dry skin
- Minimize shear and friction through (proper positioning, transferring & turning techniques, protective dressings, skin sealants or corn starch)
- Use moisture barriers
- Consult with Dietary and Therapy departments to enhance care continuity
- Pay attention to nutrition & hydration
- Facilitate mobility through activity, ROM exercises and positioning
- Use pressure reduction devices in bed, chair and wheelchair
- Use positioning devices to pad bony prominences
- Relieve heel pressure in bed
- Maintain HOB at lowest possible elevation
- Use lifting devices
- Involve/educate resident, family and staff in PREVENTION BASICS.

DO NOT

- Use hot water
- Use donut-type devices
- Massage skin over bony prominence

STAGE 1 or DEEP TISSUE INJURY (Intact Skin)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP topical treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 1 SOP:
1) Monitor area
2) Protect skin from moisture/incontinence with barrier ointment

TOPICAL & DRESSING SUPPLIES (see back of card for clinic/facility specific brands)

***DO NOT use Hydrocolloid dressings or transparent films on infected wounds.**

****DO USE SILVRSTAT gel in place of Hydrogel whenever infection is possible, suspected or present.**

(See STANDING ORDERS for ARTERIAL and VENOUS WOUNDS on back of card.)

STAGE 2 (Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity

Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 2 SOP:
Cleanse with sterile water or peri-wash initially & at each dressing change
Protect peri-wound (skin sealant/barrier)
NO DRAINAGE
Apply SILVRSTAT** to wound base **q3** days with cover dressing
OR

3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING
Apply adhesive foam **QD**
OR

4b) If wound has depth loosely fill with lightly moist sterile gauze and cover dressing QD

STAGE 3 & 4 (Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity

Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following **SOP** until order is obtained.

STAGE 3 & 4 SOP:
1) Cleanse with sterile water initially & at each dressing change
2) Protect peri-wound (skin sealant/barrier)

NO DRAINAGE
3) Apply SILVRSTAT** to wound base **QD** with cover dressing
OR

3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING
4) Apply adhesive foam **QD**
OR

4b) If wound has depth layer Calcium Alginate in or over slough area before applying SILVRSTAT, loosely fill with lightly moist sterile gauze and cover apply cover dressing QD

UNSTAGEABLE, DISEASE & TRAUMA WOUNDS

***DEFINITION*: UNSTAGEABLE WOUNDS are all wounds that are covered by Eschar or slough or caused by disease trauma/BURNS.**

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity

Start PREVENTION BASICS

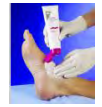
STANDING ORDERS:
If awaiting Physician/NP treatment orders, use the following **SOP** until order is obtained.

INTACT BLACK HEEL SOP:
1) Relieve pressure (pillow, prop etc.)
2) Leave intact unless S/S of infection
3) Cover with DRY gauze

MACERATION/ EXCORIATION/EDEMA SOP:
1) Cleanse w sterile water or peri-wash
2) Apply barrier ointment following each episode of incontinence
3) If edema is suspected cause call physician immediately

SKIN TEARS SOP:
1) Cleanse w sterile water or peri-wash
2) Apply thin layer SILVRSTAT** let dry ***BEFORE***
3) Appling Steri Strips or cover with transparent film*. Change **q5** days or PRN for dislodgement or leakage

LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

UNSTAGEABLE, DISEASE & TRAUMA WOUNDS	PRODUCT TYPES & CATEGORIES (9)	PRODUCT BRANDS & OPTIONS (18)	PRODUCT PHOTOS
START STANDARD DOs w **PREVENTION BASICS** **STANDING ORDERS:** If awaiting Physician/NP treatment orders, use the following **STANDARD SOP** until order is obtained. **DIABETIC WOUNDS SOP:** 1) Cleanse w sterile water or peri-wash 2) Fill wound depth with SILVRSTAT** 3) Cover with transparent film* or Hydrocolloid* Change **q3** days ***IF DRAINING*** **3b)** Cover with foam and change **QD** **BURNS SOP:** 4) Relieve pressure (pillow, prop, fluidized mattress etc.) 5) Irrigate burn are with sterile water 6) Apply SILVRSTAT to burn area 7) Cover entire area with moist dressings *OR* sterile gauze dampened with SILVRSTAT 8) Assess pain level, administer pain meds PRN 9) Change **q3** ***IF DRAINING*** **6b)** change dressings **QD** **ARTERIAL WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Change **q3** days ***IF* DRAINING** **6b)** change dressings **QD** **VENOUS WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Elevate leg as long as tolerated by patient **BID** 7) Change **q3** days ***IF DRAINING*** **7b)** change dressings **QD**	**WOUND CLEANSING** **Irrigation/Peri-wash**	**Sterile Water (B BRAUN); Peri-Wash (Convatech)**	
	TRANSPARENT FILM	**Tegaderm Transparent Dressing (3M); OpSite (Smith & Nephew)**	
	HYDROGEL	**SILVRSTAT** (ABL Medical)**	
	HYDROCOLLOID	**Tegaderm Hydrocolloid Thin (3M); DuoDERM Extra Thin (Convatec)**	
	FOAM	**Allevyn Non-adhesive or Allevyn Adhesive (Smith & Nephew); Tegaderm Foam Adhesive (Smith & Nephew)**	
	CALCIUM ALGINATE	**Sorbsan (Mylan-Bertek); Algisite M (Smith & Nephew)**	
	COVER DRESSINGS	**Tegaderm+Pad (3M);Non-Adherant Pads (Kendall); Telfa Island Dressing (Kendall)**	
	BARRIER OINTMENTS	**Calmoseptine; Cavilon (3M)**	
	SKIN SEALANT	**Cavilon (3M); Skin Prep (Smith & Nephew)**	 **© Copyright Pacent/LTC Professionals 2012**

Patient name/Sticker

_____

Room: DOB:

Standing House and Protocol Check list Order

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- ☐ **Wound Care Protocol**

Provider Signature:_____ Date:_____

Nurse Review___ (Initials)

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2. After business hours and all day on weekends and holidays, contact the on-call staff with:
   - Critical patient care issues that need to be addressed prior to the next NP/MD visit
   - Clarification of admission orders that represent critical concerns
3. Otherwise contact the primary care team on the next business day for all other concerns

Admission to Facility

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- **For patients with CHF**
  - Daily weights
  - Call for weight gain >2.5# in 48 hours or 5 # above admission weight
  - Assess lung sounds, peripheral edema, and respiratory effort daily
- Physical therapy, Occupational therapy and/or Speech therapy to evaluate and treat as indicated
- Administer facility mental status testing and PHQ9 section of the MDS.
- Administer two-step Mantoux unless history of TB or positive PPD.
- If PPD has been positive or contraindicated, a negative chest x-ray within three months in advance of admission or within 72 hours after admission is required. Fax results to NP/MD next business day unless results are abnormal. Obtain copy of CXR report to document “active TB negative” status.
- May administer influenza vaccine to patients who have not already received it unless contraindicated (i.e., temp> 100° F, allergy to eggs or influenza vaccine), per CDC guidelines.
- May administer Pneumovax to patients that have not already received it unless contraindicated, per CDC guidelines.

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- When specific diet orders are not present, the nurse or dietitian may initiate a diet that conforms to the facility's dietary options and best meets the patient's needs
- May change diet to house equivalent
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- Acetaminophen 650 mg Q 4 hours PRN pain not to exceed 3000mg of acetaminophen in 24 hours
    - (not fever – call NP/MD for all new fever episodes)
    - All patients -acetaminophen not to exceed 3 grams per 24 hours regardless of admission orders
- Cepacol (or therapeutic equivalent) (regular or sugar free) 1 lozenge dissolved in mouth q 2 hours PRN for sore throat
- Apply ice for 20 min qid PRN to injuries with inflammation
- Preparation H or Anusol ointment (or therapeutic equivalent) per package instructions PRN after bowel movement for hemorrhoid pain
- Lidocaine 1% 1.8 ml as a diluent with IM Rocephin PRN for local anesthesia

Respiratory

- Guaifenesin (plain) 2 tsp PO q 6 hours PRN for upper respiratory symptoms (cough, runny nose, sore throat, nasal congestion)(expectorant)
- Albuterol 2.5 mg NEB x one dose PRN for dyspnea or wheezing **AND call NP/MD with a nursing assessment**
- O2 via nasal cannula 1-4 L per minute PRN for dyspnea, hypoxia (02 saturation <88%) or acute angina **AND call NP/MD with a nursing assessment**[S2]
- May initiate O2 weaning per nursing judgment to keep O2 sats >88%; monitor O2 saturations q shift X 3 days after oxygen is discontinued, including one O2 saturation during night-time sleep In patients with a tracheostomy, initiate trach care per facility protocol, suction PRN, and use a trach dome when O2 is indicated

Cardiovascular

- Nitroglycerin 0.4 mg SL PRN for chest pain or other signs/symptoms of acute angina; may repeat q 5 minutes x 2
- If chest pain/acute angina is not relieved after two doses of nitroglycerin, call 911 unless contrary to advanced directives; **notify NP/MD immediately**.

Indigestion

- Antacid (facility stock) 30 ml PO qid PRN

Note -magnesium-based products are contraindicated for renal patients Tums (or therapeutic equivalent) 500 mg 1 tab PO (chewable) qid PRN

Sleep

- Institute 3 day sleep record by nursing staff

Cerumen

- Debrox or mineral oil 3 drops to affected ear bid x 3 days
- Gently irrigate affected ear canal with tepid H20 on 4th day
- Repeat x I if indicated and update NP/MD

MD/NP provider _____

Blood Sugar Management Protocol

- Initiate meal time and bedtime blood glucose (BG) monitoring upon admission X 7 days for ALL diabetic patients unless admitting orders specify otherwise[S3]
- Notify NP/MD if two blood glucose results are < 70 or > 400 in a 24 hr period and/or condition change. If no condition change notify during next business day.
- If not specified: no coverage with insulin at HS

Hyperglycemia (BG > 200)

- Administer NovoLog insulin < 15 minutes before the meal due to rapid onset of action Use the following sliding scale when a sliding scale is ordered but dose is not specified.

Blood glucose	> 450	12 units subcutaneously (sc)
Blood glucose	400 -450	10 units sc
Blood glucose	350 -399	8 units sc
Blood glucose	300 -349	6 units sc
Blood glucose	250 -299	4 units sc
Blood glucose	200 -249	2 units sc
Blood glucose	< 200	0 units

Hypoglycemia (BS < 70)

- If patient is symptomatic, conscious, and able to swallow or has a feeding tube:
  - Administer 6 oz. fruit juice, milk, regular pop, or other high carbohydrate beverage (i.e., Ensure, Boost) orally or via feeding tube
  - Repeat BG after 10 minutes; if < 70, repeat above intervention
  - Repeat BG again in 10 minutes; if< 70 and equipment is determined to be functioning accurately, administer tube of Glucose Gel
  - If BG remains < 70 on a fourth test, notify NP/MD
- If patient is unresponsive or unable to swallow and does not have a feeding tube: ○ Administer Glucagon 1 mg IM
  - Repeat BG after 10 minutes; if < 70 and patient still unresponsive, repeat Glucagon and notify NP/MD immediately.
  - Call 911 while waiting for NP/MD response.
  - If BG remains < 70 but patient is conscious, initiate interventions for the conscious patient
  - Communicate occurrence of any hypoglycemic event to NP/MD the next working day

MD/NP provider _____

Bowel Management Protocol

Bowel: Diarrhea

- Stop all cathartic (constipation) related meds and observe If diarrhea continues:
- Send stool specimen for C. diff toxin A and B
- Initiate clear liquid diet for 24 hours
- Notify NP/MD of the change in condition

Bowel: Constipation

- Perform rectal check for impaction
- Encourage 2,000 ml daily fluid intake unless contraindicated
- Dietary to initiate high fiber diet or supplements
- Order: Senna S 1 tab po bid prn
- If no BM x 1 day then schedule Senna S 1 tab po bid
- If no BM x 2 days start Miralax 17gm po q d
- If no BM x 3 days then Bisacodyl suppository 10 mg PR every 3 days PRN
- Fleets enema PR every 3 days PRN if no results from suppository, do not use in renal failure or renal insufficiency)

MD/NP provider _____

Bladder Management Protocol

- Discontinue urinary catheter unless the admitting H & P indicates a diagnosis of neurogenic bladder, prostate hypertrophy with obstruction or urinary retention. If placed for wound management call before removing.
- After removing the catheter:
  - Assess voiding q 6 h with bladder scan or history
  - If PVR is > 250 cc on scan, no voiding in 6 hours, nursing assessment by palpation of full bladder, or patient uncomfortable: straight catheter
  - Ok to use lidocaine jelly 2% catheter lubricant
  - Continue striaght catheter q 6 hrs until patient voiding spontaneously

- **Care of the indwelling catheter**
  - Do not irrigate
  - Change chronic catheter q month, use same catheter and balloon size that patient has had placed previously
  - Change catheter bag q week
  - Change PRN for leaking or decreased urinary output with similar sized catheter Change catheter and tubing prior to obtaining a UA/UC
  - Ensure bag is not touching the flow
  - May attach leg bag when patient is up, reattach straight drainage when in bed

MD/NP provider _____

IV Line Management Protocol

- Initiate routine IV line and site care per facility protocol
- May replace peripheral line per facility protocol or pm for site infiltration or phlebitis
- May DC PIV site if no indication for use. DO NOT remove PICC or central lines without consulting MD/NP.

- PICC line to be used for all antibiotics greater than 5 days
- PICC line insertion by IV team
- CXR for placement
- Once placement confirmed by IV nurse or provider may use for infusion
- OK to use PICC line for blood draws
- Flushes per Pharmacy or facility IV protocol

MD/NP provider _____

After Hours INR Coverage

.

WEEKENDS and AFTER 5:00 PM INR Protocol
Coumadin Management-DVT or PE or CVA or A fib
INR Goal 2.0-3.0

INR <2.0 Call on-call for further directions

INR 2.0-3.0 Give same Coumadin dose-Notify primary MD/NP for further INR/Coumadin orders.

INR 3.0-5.0 Hold dose of Coumadin-Check INR in AM, call primary MD/NP with results (on-call staff if primary MD/NP is not available) for INR/Coumadin orders.

INR >5 Call on-call staff for further directions.

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

WEEKEND and AFTER 5:00 PM INR Protocol
Coumadin Management-Joint Replacement Prophylaxis
INR Goal 1.8-2.5

INR <1.8 Call on-call staff for further directions

INR 1.8-2.5 Give same Coumadin dose-Notify primary MD/NP in the AM (on-call staff if primary MD/NP not available) for further INR/Coumadin orders.

INR 2.5-5.0 Hold dose of Coumadin-Check INR in AM, contact primary MD/NP with results (on-call staff if MD/NP not available) for INR/Coumadin orders

INR >5.0 Call on call staff for further directions

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

WEEKEND and AFTER 5:00 PM INR Protocol
Coumadin Management-Mechanical Heart Valve
INR Goal 2.5-3.5

INR <2.5 Call on-call staff for further directions

INR 2.5-3.5 Give same Coumadin dose-Notify primary MD/NP in the AM (on-call staff if primary MD/NP not available) for further INR/Coumadin orders.

INR 3.5-5.0 Hold dose of Coumadin-Check INR in AM, contact primary MD/NP with results (on-call staff if MD/NP not available) for INR/Coumadin orders.

INR >5.0 Call on-call staff for further directions

***If INR draw is missed give same dose of Coumadin, check INR in the morning**

MD/NP provider _____

LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

PREVENTION BASICS

DO:

- Complete Braden & Comprehensive Assessment
- Reposition ***at-risk residents*** per individual sitting and lying intervals
- Daily skin inspections with cares
- Weekly skin inspections by LPN or RN include measurements
- Minimize exposure to moisture (incontinence, perspiration, drainage etc.)
- Moisturize dry skin
- Minimize shear and friction through (proper positioning, transferring & turning techniques, protective dressings, skin sealants or corn starch)
- Use moisture barriers
- Consult with Dietary and Therapy departments to enhance care continuity
- Pay attention to nutrition & hydration
- Facilitate mobility through activity, ROM exercises and positioning
- Use pressure reduction devices in bed, chair and wheelchair
- Use positioning devices to pad bony prominences
- Relieve heel pressure in bed
- Maintain HOB at lowest possible elevation
- Use lifting devices
- Involve/educate resident, family and staff in PREVENTION BASICS.

DO NOT

- Use hot water
- Use donut-type devices
- Massage skin over bony prominence

STAGE 1 or DEEP TISSUE INJURY

(Intact Skin)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity
- Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP topical treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 1 SOP:
1) Monitor area
2) Protect skin from moisture/incontinence with barrier ointment

TOPICAL & DRESSING SUPPLIES
(see back of card for clinic/facility specific brands)

***DO NOT use Hydrocolloid dressings or transparent films on infected wounds.**

****DO USE SILVRSTAT gel in place of Hydrogel whenever infection is possible, suspected or present.**

(See STANDING ORDERS for ARTERIAL and VENOUS WOUNDS on back of card.)

STAGE 2

(Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity

Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following STANDING ORDER PROTOCOL (**SOP**) until order is obtained.

STAGE 2 SOP:
Cleanse with sterile water or peri-wash initially & at each dressing change
Protect peri-wound (skin sealant/barrier)

NO DRAINAGE
Apply SILVRSTAT** to wound base **q3** days with cover dressing
OR

3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING
Apply adhesive foam **QD**
OR

4b) If wound has depth loosely fill with lightly moist sterile gauze and cover dressing QD

STAGE 3 & 4

(Pressure Sores)

DO:

- Notify physician to obtain diagnosis/orders
- Notify family and/or Representative, Designee etc.
- Start weekly wound round and documentation
- Complete Braden and collect comprehensive risk data
- Complete Tissue Tolerance observation
- Consult with Dietary & Therapy departments as necessary
- Protect heels from pressure (pillow prop or lift boots)
- Evaluate bed & w/c surface
- Develop Care Plan for Skin Integrity

Start PREVENTION BASICS

STANDING ORDERS:
If awaiting Physician/NP treatment orders use the following **SOP** until order is obtained.

STAGE 3 & 4 SOP:
1) Cleanse with sterile water initially & at each dressing change
2) Protect peri-wound (skin sealant/barrier)

NO DRAINAGE
3) Apply SILVRSTAT** to wound base **QD** with cover dressing ***OR***

3b) If wound needs protection from incontinence use Hydrocolloid* **q3** days & PRN

DRAINING
4) Apply adhesive foam **QD**
OR

4b) If wound has depth layer Calcium Alginate in or over slough area before applying SILVRSTAT, loosely fill with lightly moist sterile gauze and cover apply cover dressing QD

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LTC Professionals STANDARD SNF WOUND CARE PROTOCOLS©

UNSTAGEABLE, DISEASE & TRAUMA WOUNDS	PRODUCT TYPES & CATEGORIES (9)	PRODUCT BRANDS & OPTIONS (18)	
START STANDARD DOs w **PREVENTION BASICS** **STANDING ORDERS:** If awaiting Physician/NP treatment orders, use the following **STANDARD SOP** until order is obtained. **DIABETIC WOUNDS SOP:** 1) Cleanse w sterile water or peri-wash 2) Fill wound depth with SILVRSTAT** 3) Cover with transparent film* or Hydrocolloid* Change **q3** days ***IF DRAINING*** **3b)** Cover with foam and change **QD** **BURNS SOP:** 4) Relieve pressure (pillow, prop, fluidized mattress etc.) 5) Irrigate burn are with sterile water 6) Apply SILVRSTAT to burn area 7) Cover entire area with moist dressings *OR* sterile gauze dampened with SILVRSTAT 8) Assess pain level, administer pain meds PRN 9) Change **q3** ***IF DRAINING*** **6b)** change dressings **QD** **ARTERIAL WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Change **q3** days ***IF* DRAINING** **6b)** change dressings **QD** **VENOUS WOUND SOP:** 1) Cleanse with sterile water or peri-wash 2) Apply SILVRSTAT** over wound surface 3) Cover wound with moist non-adherent pads or dressings 4) Assess pain level, administer pain meds PRN 5) Secure dressing using gentle tension, with gauze, cloth or paper tape 6) Elevate leg as long as tolerated by patient **BID** 7) Change **q3** days ***IF DRAINING*** **7b)** change dressings **QD**	**WOUND CLEANSING** **Irrigation/Peri-wash**	**Sterile Water (B BRAUN); Peri-Wash (Convatech)**	
	TRANSPARENT FILM	**Tegaderm Transparent Dressing (3M); OpSite (Smith & Nephew)**	
	HYDROGEL	**SILVRSTAT** (ABL Medical)**	
	HYDROCOLLOID	**Tegaderm Hydrocolloid Thin (3M); DuoDERM Extra Thin (Convatec)**	
	FOAM	**Allevyn Non-adhesive or Allevyn Adhesive (Smith & Nephew); Tegaderm Foam Adhesive (Smith & Nephew)**	
	CALCIUM ALGINATE	**Sorbsan (Mylan-Bertek); Algisite M (Smith & Nephew)**	
	COVER DRESSINGS	**Tegaderm+Pad (3M);Non-Adherant Pads (Kendall); Telfa Island Dressing (Kendall)**	
	BARRIER OINTMENTS	**Calmoseptine; Cavilon (3M)**	
	SKIN SEALANT	**Cavilon (3M); Skin Prep (Smith & Nephew)**	

ALLINA HOSPICE & PALLIATIVE CARE
Allina Hospitals & Clinics

Hospice Comfort Care Kit

Date: 03-19-14 Hospice Benefit: Medicare

Residential Care: Renting

Patient Name: [redacted]

DOB: 12-14-1922 Social Security Number: _____

Allergies: [redacted]

Patient Address/Service Location: [redacted]

Phone Number: [redacted]

Physician Name (Print): [redacted]

Physician Telephone Number: [redacted]

Hospice Comfort Care Kit

For use in emergent situations only. Please X out what is not appropriate.

1. Prochlorperazine (Compazine) 10 mg tablet PO q6h prn nausea/vomiting #2
2. Atropine 1% ophthalmic 5 ml instill 2 drops SL q4h prn copious secretions
3. Lorazepam (Ativan) 1 mg tablet 0.25-2 mg PO/SL/buccally/PR q4-6h prn anxiety/agitation #3
4. Morphine soln 20mg/ml oral solution 5-15 mg q2-4h PO/SL prn pain/SOB #30ml
5. Haloperidol soln 2mg/ml oral solution 0.5-1 mg PO/SL nausea/agitation/severe anxiety/hallucinations; may dose 5-10mg q6h for acute agitation #120ml
6. Benadryl 25mg/Dexamethasone 4mg/Reglan 10mg (BDR) suppository one PR q6-8h prn nausea/vomiting #2
7. Ativan 0.5mg/Benadryl 12.5mg/Haldol 1mg/Reglan 10mg (ABHR) suppository one PR q4-6h prn intractable nausea/vomiting #2

Signature of Physician: [redacted] Date 03/19/14

Physician's DEA #: _____

Revised: Oct 2005

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