A UMC Health System Performance Improvement Initiative for use in all units where surgical patients receive care in support of Surgical Care Improvement Program (SCIP).

* Denotes guideline requirement for Core Measures

1. Attending Physician: ___________________________ Resident/Fellow: ___________________________
3. Code Status: ☐ Full Code ☐ DNR ☐ Comfort Care ☐ Other: ________________________________
4. Co-Morbidities: _______________________________________________________________________
5. Allergies: ☐ NKDA Allergic to: _______________________________________________________________________

CONSULTS:
☐ Consult Anesthesia for Pain Management
☐ Consult ____________________________________________________

CONSULTS:

NURSING:
Vital Signs: ☐ Routine post op VS ☐ every 4 hours ☐ Other: ___________________________ (See notification orders on last page)
Intake and output: ☐ Hourly ☐ Every Shift ☐ Other: _____________________________
Foley Care: ☐ Daily ☐ Ok to irrigate as needed ☐ Notify MD for urine output < 30 mL/hr
* FOLEY ☐ Dc Foley at ____________ ☐ POD #1 __________ ☐ POD #2 __________
Other – please specify: __________________________________________________________________________
☐ Straight cath every 6 hrs pm, if unable to void ☐ Reinsert foley catheter if straight cath required more than 2 times
Diet: ☐ NPO ☐ Clear Liquids ☐ Full Liquids ☐ Mechanical Soft ☐ Regular ☐ Advance As tolerated with Flatus
☐ Other: ___________________________________________________________________________________
Activity:
☐ Turn, Cough, and Deep Breathe every ______ hours for ______ hours
☐ Bedrest
☐ Bathroom privileges
☐ Sit at side of bed
☐ Other: ___________________________________________________________________________________

Treatments:
Incision Care:
☐ Notify House Officer if excessive drainage or bleeding ☐ Per physician
☐ Other: _____________________________
☐ MD to remove Vaginal Packing on Post op Day _____________ ☐ Other: _____________________________
☐ K-Pad PRN ☐ Chux Pad PRN
Drain Care:
☐ None ☐ ___________________________________________ Record output every ______ hrs

☐ TO ☐ Read back
Order taken by Signature: ___________________________ Date/Time ___________________________
Physician Signature ___________________________ Date/Time ___________________________

Antibiotic administered in the OR at: ____________
8. LABORATORY/DIAGNOSTICS:
   - CBC: Post op: □ Day 1  □ Day 2  □ Day 3  Notify Physician if: ________________________________
   - Basic metabolic profile: Post op: □ Day 1  □ Day 2  □ Day 3  Notify Physician if: ________________________________
   - Other: ____________________________________________________________
   - X-Ray: ____________________________________________________________

9. RESPIRATORY THERAPY:
   - O₂ @ _____ liters/minute via ________________________________
   - SaO₂ Monitoring – every _______ hours
     - Discontinue oxygen therapy if SaO₂ consistently 92% or greater
     - O₂ saturations < 92% on room air; re check BID until > 92% on room air
     - Call physician if saturations continue at < 92% on room air
   - Incentive spirometer x 10 over 30 minutes every _______ hours while awake, until discharge
   - Other: ____________________________________________________________

10. IV:
   - Continuous IV fluids: Ringers Lactate to run at ________________________________ml/hr
   - Convert IV to INT at 0600. Post op: □ When tolerating PO  □ Day 1  □ Day 2  □ Day 3
   - Maintain saline lock  □ INT for blood draws. Flush with NS q 4 hours and prn
   - Discontinue INT: □ Post op: □ Day 1  □ Day 2  □ Day 3

11. MEDICATIONS:  (Refer also to Admission Medication Reconciliation Form and Discomfort Orders)
    * Prophylactic Antibiotic Therapy: *Antibiotic discontinued 24 hours after Anesthesia end time.
      (Select one of the following)
      - Cefotetan  □ Cefazolin (Ancef, Kefzol)  □ Cefoxitin (Mefoxin)  □ Cefuroxime  □ Ampicillin/Sulbactam (Unasyn) _______ IV ____________________________ (dc 24 hours post op)
      - β-lactam allergy: (Select one of the following)
        - Clindamycin PLUS Aminoglycoside (Select one of the following) □ Amikacin  □ Gentamycin  □ Tobramycin _______ IV ____________________________ (dc 24 hours post op)
        - Clindamycin PLUS Quinolone (Select one of the following) □ Cipro  □ Moxifloxacin  □ Levofloxacin _______ IV ____________________________ (dc 24 hours post op)
        - Clindamycin PLUS Azetreonam _______ IV _______________ (dc 24 hours post op)
      OR
      - Metronidazole PLUS Aminoglycoside (Select one of the following) □ Amikacin  □ Gentamycin  □ Tobramycin _______ IV ____________________________ (dc 24 hours post op)
      - Metronidazole PLUS Quinolone (Select one of the following) □ Cipro  □ Moxifloxacin  □ Levofloxacin _______ IV ____________________________ (dc 24 hours post op)

(MEDICATIONS CONTINUED BELOW)
MEDICATIONS: (CONTINUED)

Therapeutic Antibiotic – Antibiotic coverage ordered for greater than 24 hours post op, requires documentation of indication.

☐ Therapeutic Antibiotic: ____________________________________________

Reason antibiotic was continued or added greater than 24 hours post-operatively (48 hours for Coronary Artery Bypass Graft [CABG]): Must be documented by physician / advance practice nurse / physician assistant within 2 days (3 days for CABG or other cardiac surgery) following the principle procedure with the day of surgery being Day Zero.

☐ Abscess/mmeg  
☐ Acute abdomen  
☐ Aspiration pneumonia  
☐ Bloodstream infection  
☐ Bone infection  
☐ Cellulitis  
☐ Endometritis  
☐ Fecal Contamination  
☐ Free air in abdomen  
☐ Gangrene  
☐ H. pylori  
☐ Necrosis  
☐ Necrotic/ischemic/infarcted bowel  
☐ Osteomyelitis  
☐ Other documented infection  
☐ Penetrating abdominal trauma  
☐ Perforation of bowel  
☐ Pneumonia or other lung infection  
☐ Purulence/pus  
☐ Surgical site or wound infection  
☐ Urinary tract infection (UTI)  

☐ (*Required if home medication) Beta Blocker: _____________________________ mg PO ______________________

Unless contraindicated as listed here: ___________________________________________________________________________________ (hold for SBP < __100____ HR < __50____)

12. PROPHYLAXIS:

* VTE Prophylaxis:  * Start within 24 hours of Anesthesia end time.
☐ *Start within 12 hrs. Post-operatively
☐ *Start within 24 hrs. Post-operatively
☐ SCDs  ✔ Plexi pulse (foot pumps)  ☐ _____ hours per day  ☐ While in bed
☐ TED Hose (thigh high)  ☐ _____ hours per day
☐ Heparin 5000 units SQ  ☐ BID  ☐ every 8 hours
☐ Warfarin (Coumadin) ☐ _____ PO every______ hours
☐ Enoxaparin (Lovenox)  ☐ 30 mg SQ daily  (Crl < 30ml/min)  ☐ 40 mg SQ daily
☐ Other: ___________________________________________________________________________________________________

Reason for not administering venous thromboembolism prophylaxis: Must be documented by physician / advance practice nurse / physician assistant within 24 hours of Anesthesia end time.

☐ Bleeding risk  
☐ Gastrointestinal bleed  
☐ Hemorrhage  
☐ Patient refusal  
☐ Thrombocytopenia  
☐ Excessive bleeding  
☐ Active bleeding (gastrointestinal bleeding, cerebral hemorrhage, retroperitoneal bleeding)  
☐ Patients on continuous IV Heparin therapy within 24 hours before or after surgery

GI:

☐ Proton Pump Inhibitor: Esomprazole (Nexium) 40 mg PO Daily
☐ H2 Blocker: Pepcid 20 mg PO BID

13. NOTIFICATION OF PHYSICIAN FOR:

☐ Temp > ________ degrees
☐ HR/Pulse < _________ bpm > _______bpm
☐ SBP < _________ > ___________
☐ DBP < _________ > ___________
☐ Respiratory Rate: < ________ > ______________
☐ Excessive vaginal or incision bleeding
☐ TO  ☐ Read back

Order taken by Signature: ________________________________ Date/Time __________________________________

Physician Signature ________________________________ Date/Time ______________________________
Indicate desired medications by checking appropriate box. If more than one box is checked for an indication, then use the ordered medications in the descending order.

PAIN MANAGEMENT: (TARGET MAXIMUM OF 3000 MG OF ACETAMINOPHEN PER 24 HOURS FROM ALL SOURCES) (DO NOT EXCEED 4000MG OF ACETAMINOPHEN PER 24 HOURS)

MILD PAIN (Pain Scale 1-3):
- Acetaminophen (Tylenol) 500–1000 mg PO every 4 hours PRN mild pain (Do not exceed 4,000 mg in 24 hours), if NPO use:
- Acetaminophen (Tylenol) 650 mg suppository PR every 4 hours PRN mild pain (Do not exceed 4,000 mg in 24 hours), if acetaminophen is ineffective/contraindicated use:
- Ibuprofen (Motrin) 400 mg PO every 6 hours PRN mild pain (Do not exceed 3,200 mg in 24 hours)
- Other______________________________

MODERATE PAIN (Pain Scale 4-7):
- Hydrocodone/acetaminophen (Lortab) 5/500 mg 1–2 tabs PO every 4 hours PRN moderate pain (Do not exceed 4 grams of acetaminophen in 24 hours), if ineffective/contraindicated or NPO use:
- Ketorolac (Toradol) 15–30 mg IV every 6 hours PRN moderate pain x 48 hours (May give IM if no IV access)
- Other______________________________

SEVERE PAIN (Pain Scale 8-10):
- Morphine 2–4 mg slow IV push every 4 hours PRN severe pain, if ineffective/contraindicated use:
- Hydromorphone (Dilaudid) 1 mg slow IV push every 4 hours PRN severe pain
- Other______________________________

NAUSEA/VOMITING:
- Promethazine (Phenergan) 25 mg PO every 4 hours PRN nausea/vomiting, if ineffective/contraindicated or NPO use:
- Ondansetron (Zofran) 4 mg IV every 8 hours PRN nausea/vomiting
- Other______________________________

BOWEL MANAGEMENT:
- Docusate (Colace) 100 mg PO at bedtime PRN for constipation, if contraindicated or ineffective after 12 hours use:
- Bisacodyl (Dulcolax) 10 mg suppository PR daily PRN constipation, if contraindicated or ineffective after 6 hours use:
- Sodium phosphate enema (Fleet enema) PR daily PRN constipation (Do not use in renal patients)
- Other______________________________

INDIGESTION/GAS:
- Aluminum hydroxide/magnesium hydroxide (Maalox) 30 ml PO every 4 hours PRN indigestion
- Simethicone (Mylicon) 80–160 mg PO every 4 hours PRN gas/bloating
- Other______________________________

DIARRHEA:
- Loperamide (Imodium) 4 mg PO initially then 2 mg PO with each loose stool (Max 16 mg hours)
- Other______________________________
Indicate desired medications by checking appropriate box. If more than one box is checked for an indication, then use the ordered medications in the descending order.

ANXIETY:

☐ Alprazolam (Xanax) 0.25 mg PO three times a day PRN anxiety, if ineffective/contraindicated or NPO use:
☐ Lorazepam (Ativan) 0.5 – 1 mg IV every 6 hours PRN anxiety
☐ Other______________________________________________________________

SLEEPLESSNESS:

☐ Zolpidem (Ambien) 5 mg PO at bedtime PRN sleeplessness, may repeat x 1 in one hour if ineffective
☐ Other______________________________________________________________

ALLERGIC REACTIONS:

☐ Diphenhydramine (Benadryl) 25 mg PO every 4 hours PRN itching, if ineffective or NPO use:
☐ Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN itching
☐ Other______________________________________________________________

COUGH / SORE THROAT:

☐ Phenol-menthol (Cepastat) 1 lozenge PO PRN sore throat (Do not exceed 6 lozenges in 24 hours)
☐ Guaifenesin/dextromethorphan (Robitussin DM) 10 ml PO every 4 hours PRN cough
☐ Other______________________________________________________________

TEMPERATURE:

☐ Acetaminophen (Tylenol) 500–1000 mg PO every 4 hours PRN fever (Do not exceed 4,000 mg in 24 hours), if ineffective/contraindicated use:
☐ Ibuprofen (Motrin) 200–400 mg PO every 4 hours PRN fever (Do not exceed 3,200 mg in 24 hours)
☐ Other______________________________________________________________

HEMORRHOIDS:

☐ Witch hazel/glycerin (Tucks) pads at bedside wipe affected area as PRN, if ineffective use:
☐ Mineral oil/petrolatum/phenylephrine (Preparation H) ointment apply to affected area every 6 hours PRN. If ineffective/contraindicated use:
☐ Pramoxine/hydrocortisone (Proctofoam HC) at bedside apply to affected area every 8 hours PRN

MUCOSITIS:

☐ Dexamethasone/diphenhydramine/nystatin/NS (Fred’s Brew) 15 ml swish and spit every 2 hours while awake PRN mucositis. If ineffective/contraindicated use:
☐ Viscous lidocaine (Xylocaine) 15 ml swish and spit every 4 hours PRN mucositis

BLADDER SCAN:

☐ Bladder scan as needed for patients complaining of urinary discomfort and/or bladder distention present OR 6 hours post-Foley removal and patient has not voided. If bladder scan volume is >250 ml please notify the physician.

OTHER:

________________________________________________________________________
________________________________________________________________________