

UMC Health System PICU TRAUMATIC BRAIN INJURY (TBI) PLAN	Patient Label Here
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PHYSICIAN ORDERS

Diagnosis _____

Weight _____ **Allergies** _____

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER ORDER DETAILS

Patient Care

Patient Activity
 Bedrest, Bed Position: HOB Greater Than or Equal to 30 degrees
 Maintain head midline, Maintain cervical spine precautions/full spine precautions

Perform Neurological Checks
 Special Instructions, with Vital Signs q15min
 q30min q1h

Pupil Exam by Pupillometer

Cerebral Perfusion Pressure Monitoring

ICP Monitoring

Set Up for External Ventricular Device P (Set Up for External Ventricular Device Placement)

Maintain External Ventricular Drain

Communication

Notify Provider of VS Parameters
 Temp Greater Than 37.5 C, Temp Less Than 36 C, pCO2 less than 35 mmHg, or pCO2 greater than 40 mmHg

Notify Provider of VS Parameters
 CPP Less Than 40 mmHg, For patients less than 2 months of age

Notify Provider of VS Parameters
 CPP Less Than 45 mmHg, For patients 2 months to 1 year old

Notify Provider of VS Parameters
 CPP Less Than 50 mmHg, For patients 1 to 12 years old

Notify Provider of VS Parameters
 CPP Less Than 60 mmHg, For patients greater than 12 years old

Notify Provider (Misc) (Notify Provider of Results)
 Reason: Serum sodium less than 145 mEq/dL or greater than 150 mEq/dL

Notify Nurse (DO NOT USE FOR MEDS)
 Maintain C-Collar

Notify Nurse (DO NOT USE FOR MEDS)
 Maintain minimal stimulation

Notify Nurse (DO NOT USE FOR MEDS)
 Place earplugs if no CSF otorrhea, nor skull fracture. Apply bilaterally if possible.

Medications

Medication sentences are per dose. You will need to calculate a total daily dose if needed.

CNS Medications

Loading Dose

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Order Taken by Signature: _____ Date _____ Time _____
Physician Signature: _____ Date _____ Time _____

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ORDER	ORDER DETAILS
	<p>***If both a ONE TIME and PRN mannitol 20% orders are needed, order separately***</p> <p>ONE TIME mannitol</p> <p>mannitol (mannitol 20% intravenous solution)</p> <p><input type="checkbox"/> 0.5 g/kg, IVPB, iv soln, ONE TIME, Infuse over 30 min <input type="checkbox"/> 1 g/kg, IVPB, iv soln, ONE TIME, Infuse over 30 min</p> <p><input type="checkbox"/> 2 g/kg, IVPB, iv soln, ONE TIME, Infuse over 30 min</p>
	<p>PRN mannitol</p> <p>mannitol (mannitol 20% intravenous solution)</p> <p><input type="checkbox"/> 0.5 g/kg, IVPB, iv soln, as needed, PRN other, Infuse over 30 min For intracranial pressure GREATER than 20 mmHg and Serum Osmolality LESS than 310 mOsmol/kg</p> <p><input type="checkbox"/> 1 g/kg, IVPB, iv soln, as needed, PRN other, Infuse over 30 min For intracranial pressure GREATER than 20 mmHg and Serum Osmolality LESS than 310 mOsmol/kg</p>
Immunizations	
	<p>For patients 2 months - 10 years of age - Per CDC, routine use is not recommended. Use only in patients at increased risk for meningococcal disease.</p> <p>meningococcal conjugate vaccine (meningococcal conjugate vaccine oligosaccharide - MENVEO)</p> <p><input type="checkbox"/> 0.5 mL, IM, inj, ONE TIME</p>
	<p>For patients GREATER than or EQUAL to 10 years of age.</p> <p>meningococcal group B vaccine</p> <p><input type="checkbox"/> 0.5 mL, IM, inj, ONE TIME</p>
	<p>Pneumococcal Vaccines (review recommendations)</p> <p>Pneumococcal Vaccination Recommendations</p> <p><input type="checkbox"/> ***See Reference Text***</p>
	<p>For patients 2 - 24 months of age. Certain older children may need PCV13 and/or PPSV 23 - refer to CDC Pneumococcal Vaccination Recommendations.</p> <p>pneumococcal 13-valent conjugate vaccine (pneumococcal 13-valent conjugate vaccine intramuscular suspension)</p> <p><input type="checkbox"/> 0.5 mL, IM, inj, ONE TIME</p>
	<p>For patients GREATER than 24 months of age. Certain older children may need PCV13 and/or PPSV 23 - refer to CDC Pneumococcal Vaccination Recommendations.</p> <p>pneumococcal 23-polyvalent vaccine (pneumococcal 23-polyvalent vaccine injectable solution)</p> <p><input type="checkbox"/> 0.5 mL, IM, inj, ONE TIME</p>
Laboratory	
	<p>CSF Cell Count and Differential</p> <p><input type="checkbox"/> STAT</p>
	<p>CSF Glucose Level</p> <p><input type="checkbox"/> STAT</p>
	<p>CSF Protein</p> <p><input type="checkbox"/> STAT</p>

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____



UMC Health System

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Diagnostic Tests

CT Head w/o
 STAT

MRI C-Spine w/o
 STAT

MRI Brain w/o
 STAT

EEG Request
 STAT

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____

