

Harbor-UCLA Admin/QI Infographics Table of Contents

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Verbal Orders







PROCESS FOR ED Verbal Orders

Verbal orders should be given only in time of an extreme emergency (e.g., code blue, active seizure, anaphylaxis etc) or during the course of treatment or surgical procedure (procedural sedation)
*physicians should still make every effort to place orders in computer when possible

3 Steps

1 Doc States Verbal Order  Med name, dose (with units), route	2 RN Repeat-back  Med name, dose (with units), route	3 Doc Confirms  Med name, dose (with units), route
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Troubleshooting Example

 DOC VERBAL ORDER "RN, Please administer 5 of Midazolam IV" [for a seizing patient]  Missing the dose unit
 RN REPEAT BACK "Ok, I will pull up and administer 5 ml's of Midazolam IV"
 DOC CORRECTION "Correction, please administer 5 <u>milligrams</u> of Midazolam IV"
 RN CORRECTION "Ok, correction, I will administer 5 <u>milligrams</u> of Midazolam IV"
 DOC CONFIRMATION "Yes, 5 milligrams of Midazolam IV is correct, Thank you"

Common Mistakes

Concentration differences: ie. 1:1000 vs 1:10000
Epinephrine
Sound alike: ie. "Klonopin (Clonazepam) vs Clonidine"
Units: "milliliters vs milligrams"
Route: ie. Topical vs. Systemic TXA

Sepsis Checklist

Sepsis/SEP-1 Checklist

Rm: _____
 Provider #: x_____



Step 1:

- a) If you see the Sepsis blood drop icon on the ED Trackboard
- or
- b) You are concerned your patient may meet sepsis criteria



Step 2: Initiate Verbal or In-person Team Huddle with RN + Doctor

RN Asks: "Is there a reason you do not want to initiate the Sepsis Bundle?"

↓
If NO, proceed



If YES,
Exit sheet



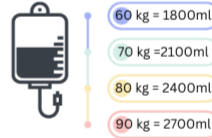
Time Zero : _____ AM/PM

(Time Severe Sepsis Criteria Met: Sepsis: Source of infection + 2 SIRS criteria (T>38.3 or <36, HR>90, RR>20, WBC <4 or >12 or >10% bands
 Severe sepsis: SBP<90, MAP<65, BiPAP/Vent, Cr>2, Uout<0.5ml/kg/hr x 2 hrs, Bili>2, Plt<100, INR>1.5, Lactate>2))

Within 3 hrs of Time Zero

- 1st Lactate** (you may check box/skip step if a lactate was obtained within 3 hours prior of Time Zero)
- Enter patient weight in chart**
- Blood Cultures (Obtain + Scan before Abx)**
- IV Antibiotics**
- IV Fluids (30 cc/kg)** *for hypotension or lactate >4
- Enter blood pressure in ORCHID after IVF**
- RN document in comments section "IVF complete"**

Doctors: use the updated ".harsepsis" dotphrase



= 3 hr Goal Time

Within 6 hrs of Time Zero

- 2nd Lactate** • draw ASAP after IVF bolus
- Physician Fluid Reassessment Documentation**
- Vasopressors** *If Septic Shock*

= 6 hr Goal Time

Quick Tips For



Severe Sepsis and Septic Shock (SEP-1)



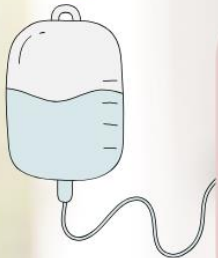
Sepsis

2 SIRS Criteria (Temp > 38.3 or < 36 , HR > 90 , RR > 20 , WBC > 12 or < 4 or 10% bands in setting of suspected or confirmed bacterial infection)

- Order cultures, lactate, antibiotics
- Only document sepsis in your MDM, differential, or note **if criteria met**

✗ “Differential: Pneumonia, Sepsis, Urosepsis”

✓ “The patient likely has pyelonephritis, I do not suspect severe sepsis.”



Severe Sepsis

Sepsis + SBP < 90 , MAP < 65 , necessitating BiPAP/Vent, Cr > 2 , Bili > 2 , Plt < 100 , INR > 1.5 , Lactate > 2 , UOP < 0.5 mL/kg/hr for 2 hours

- Document time stamp of when this was first recognized
- Order 30cc/kg fluid bolus if lactate > 3.9 or low BP (or document exemptions eg BMI or volume status)
- Order repeat lactate to be drawn after fluid completion

Septic Shock

Persistent hypotension SBP < 90 or < 40 from baseline, MAP < 65
AFTER IV fluids OR Lactate > 3.9

- Document time stamp of when this was first recognized
- Order vasopressors (if hypotensive after 30 cc/kg IVF bolus)
- Document time stamp a reassessment of hemodynamics within 6 hours (eg “I performed the sepsis reassessment at (time stamp)”)

