A THERAPEUTICALLY EQUIVALENT PRODUCT MAY BE DISPENSED AND ADMINISTERED UNLESS CHECKED IN THE LEFT COLUMN.

✓	LIVER SURGERY POST-OPERATIVE ORDERS	ROOM NO.

ALLERGIES (list reactions): HT _____ (Cm) WT _____ (Kg)

A ☑ indicates a selected order. If a defaulted order is not appropriate, draw a line through the order.

Admission Status:
Must Select One when patient is first admitted. Do NOT use to convert a patient's admission status.

- ☐ **Out-Patient Surgery / Procedure with or without Out-Patient Recovery (SDC)** e.g. expected post-procedure recovery, pain management.
- ☐ **Admit to Medical Observation (INo).** Observation is an outpatient status used to determine the need for further treatment or possible inpatient admission. Usually can be determined in less than 24 hours. Patient must meet observation criteria each hour.
- ☐ **Admit as Inpatient.** Preferred unit: _____

Diagnosis: _____

Isolation (check all that apply):

☐ Airborne precautions ☐ Contact precautions ☐ Droplet precautions

Reason for isolation:

Vital Signs & Call Orders:

- ☐ Vital signs every _____ hours until stable, then every _____ hours thereafter.
- ☐ Call MD if Temperature greater than 101.5° F.
- ☐ Call MD if Pulse less than 55 or greater than 135 / min.
- ☐ Call MD if SBP less than 100 or greater than 180 mmHg.
- ☐ Call MD if Respiratory rate is greater than 24 / min.
- ☐ Call MD if O_2 saturation is less than 90% on oxygen.
- ☐ Call MD if urine output is less than 30 or mL per hour for 2 consecutive hours.
- ☐ Other: _____

Nursing:

- ☑ Urinary catheter to gravity
- ☐ Discontinue indwelling urinary catheter in AM
- ☐ NG Tube to medium continuous wall suction; flush with 30 mL every 8 hours
- ☐ Intake and Output every _____hours
- ☑ Sequential venous compression devices to lower extremities at all times unless walking
- ☑ Maintain dry dressing to wound at all times
- ☐ Cardiac monitoring
- ☐ Daily weights
- ☑ If patient is diabetic, capillary Blood Glucose Monitor AC and HS
- ☐ Other: _____

12-hour Chart Check_____ **RN DATE:** _____ / _____ / _____ **TIME:**_____

T.O. _____ **Taken by:** _____ ____/____/____, **TIME:**_____

TRANSCRIBED BY: _____ ____/____/____, **TIME:** _____ **NOTED BY:**_____ ____/____/____, **TIME:**_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

PRINTED NAME/ID#:

(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)

St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

LIVER SURGERY POST-OPERATIVE ORDERS
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PATIENT ID

A THERAPEUTICALLY EQUIVALENT PRODUCT MAY BE DISPENSED AND ADMINISTERED UNLESS CHECKED IN THE LEFT COLUMN.

✓	LIVER SURGERY POST-OPERATIVE ORDERS	ROOM NO.

ALLERGIES (list reactions): HT _____ (Cm) WT _____ (Kg)

Activity:

☐ Bed rest X 24 hours, then ambulate per Ambulation Policy (PC-112)

Respiratory:

☐ Incentive spirometer Q 1 hour X 10 (while awake) ☐ Initiate Respiratory Therapy Oxygen Protocol (RT506)

Nutrition:

☐ NPO ☐ Clear Liquids (No Carbonated Beverages) ☐ Regular Diet
☐ Ice Chips ☐ Full Liquids (No carbonated beverages)

LAB:

☐ Now ☐ CBC ☐ CMP ☐ CEA ☐ PT ☐ aPTT ☐ BMP ☐ Phosphorus (PHOS) ☐ Magnesium (MG)
☐ In AM: ☐ CBC ☐ CMP ☐ CEA ☐ PT ☐ aPTT ☐ BMP ☐ Phosphorus (PHOS) ☐ Magnesium (MG)
☐ Other_____

IV Fluids:

☐ D5 ½ NS with _____ mmol KPhos to run at _____ mL / hour
☐ DC IV Fluids at _____, and convert to saline lock and flush per protocol.
☐ Other_____

Medications:

Analgesics: **No Acetaminophen**

☐ See PCA orders
☐ Oxycodone 5 mg: 1 Tab Po Q 4 hours as needed for moderate pain
☐ Oxycodone 5 mg: 2 Tabs Po Q 4 hours as needed for severe pain

Antibiotics:

☐ Cefoxitin _____ grams IVPB Q 8 hours X 3 doses

If prophylactic antibiotic duration exceeds 24 hours, please indicate the reason:

☐ Known infection ☐ Suspected infection ☐ Actual organism: _____

Anti-emetics:

☐ Zofran 4 mg IV Q 6 hours as needed for nausea

Other Medications:

☐ Benadryl 25 mg Po Q HS for insomnia, may repeat once

Venous Thromboembolism (VTE) prophylaxis:

☐ Enoxaparin (Lovenox) 40 mg SubQ daily POD #1 at 1800. Pharmacy to reduce dose to 30 mg SubQ daily for creatinine clearance less than 30 mL / minute.

Additional Orders:

☐ _____

12-hour Chart Check_____ **RN DATE:** _____ / _____ / _____ **TIME:**_____

T.O. _____ **Taken by:** _____ ____/____/____, **TIME:**_____

TRANSCRIBED BY: _____ ____/____/____, **TIME:** _____ **NOTED BY:**_____ ____/____/____, **TIME:**_____

PHYSICIAN SIGNATURE:_____ **DATE:** _____ **TIME:** _____

PRINTED NAME/ID#:

(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)

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LIVER SURGERY POST-OPERATIVE ORDERS
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