

ALL ORDERS MUST BE WRITTEN IN THE METRIC SYSTEM AND INCLUDE DATE, TIME, AND PRESCRIBER'S SIGNATURE. ANOTHER BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED BY THE HOSPITAL PHARMACY UNLESS SPECIFIED "BRAND ONLY" BESIDE DRUG.

DIAGNOSIS: _____

NO KNOWN ALLERGIES

AGE: _____ WT.: _____ HEIGHT: _____

ALLERGY and MEDICATION SENSITIVITY INFORMATION (Transfer to each new order)

ORDERED DATE / TIME

Severe Sepsis / Septic Shock Order Set – 3 Hour Bundle

DO NOT USE the following abbreviations:

Diagnostics – 3 Hour Bundle

U
IU
QD
QOD
MS
MSO₄
MgSO₄
ug
TIW
AS
AD
AU
OS
OD
OU

&

Trailing zero after whole number (i.e. 5.0 mg)

<input checked="" type="checkbox"/> CBC with Automated Differential Stat (required)
<input checked="" type="checkbox"/> Comprehensive Metabolic Panel (CMP) Stat (required)
<input checked="" type="checkbox"/> Prothrombin Time (PT/INR) Stat (required)
<input checked="" type="checkbox"/> aPTT (PTT) Stat (required)
<input type="checkbox"/> Perform ISTAT Lactate level Stat
<input type="checkbox"/> Lactic Acid Stat
<input type="checkbox"/> Lactic Acid Stat Repeat if 1st Lactic Acid is > 2 at least 2H post 1st result
<input type="checkbox"/> Blood Culture – Draw by Lab – Peripheral X2
<input type="checkbox"/> Blood Culture – Draw by Nurse – Peripheral X2 (ICUs, ED)
<input type="checkbox"/> Blood Culture – Nurse/Doctor Draw – Central Line Stat
<input type="checkbox"/> Urinalysis Stat
<input type="checkbox"/> Urine Culture Stat
<input type="checkbox"/> Respiratory Culture (if with productive cough) Stat
<input type="checkbox"/> EKG (ED) Stat
<input type="checkbox"/> EKG Tracing Only (EKG) Stat
<input type="checkbox"/> XR Chest PA and LAT Stat
<input type="checkbox"/> XR Chest Single View Stat Portable

MUST USE the following abbreviation:

Monitoring – 3 Hour Bundle

Leading zero before a less than whole number (i.e. 0.5 mg)

<input checked="" type="checkbox"/> Notify MD if SBP (systolic BP) is < 90 mmHg (required)
<input checked="" type="checkbox"/> Notify MD if there is decrease of 40 mmHg from last recorded SBP (required)
<input checked="" type="checkbox"/> Notify MD if MAP (Mean Arterial Pressure) is < 65 mmHg (required)
<input checked="" type="checkbox"/> Notify MD if Lactic Acid is equal to or greater than 4 mmol/L (required)

Time Order Scanned: _____

Physician Signature: _____ Name (Print): _____ Date/Time: _____ Pager: _____
 Nurse Signature: _____ Name (Print): _____ Date/Time: _____
 US Signature: _____ Name (Print): _____ Date/Time: _____



SEVERE SEPSIS / SEPTIC SHOCK ORDER SET – 3 Hour Bundle



* P 0 0 0 7 9 *

ALL ORDERS MUST BE WRITTEN IN THE METRIC SYSTEM AND INCLUDE DATE, TIME, AND PRESCRIBER'S SIGNATURE.
 ANOTHER BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED BY THE HOSPITAL PHARMACY
 UNLESS SPECIFIED "BRAND ONLY" BESIDE DRUG.

DIAGNOSIS: _____

NO KNOWN ALLERGIES

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Severe Sepsis / Septic Shock Order Set – 3 Hour Bundle

DO NOT USE
 the following
 abbreviations:

IV Fluids – 3 Hour Bundle

INSTRUCTION: Administer IV fluids ONLY IF systolic BP (SBP) < 90 mmHg or mean arterial BP (MAP) < 65 mmHg or a decrease in SBP 40 mmHg from the last recorded SBP considered normal for given patient or initial Lactate level => 4 mmol/L

(Choose ONE from below)

Sodium Chloride 0.9% IV @ 30 ml/kg – Infuse 2L rapidly by bolus

Lactated Ringers IV @ 30 ml/kg – Infuse 2L rapidly by bolus

PLASMA-LYTE-56 IN D5W IV @ 30 ml/kg – Infuse 2L rapidly by bolus

Normosol @ 30 ml/kg – Infuse 2L rapidly by bolus

Notify MD to reassess fluid tolerance after infusion of 2 liters

If pt tolerating fluids infuse each additional liter by bolus

Notify MD to assess fluid tolerance after each liter is infused

Infuse the entire amount of IV fluid equivalent to 30 ml/kg

U
 IU
 QD
 QOD
 MS
 MSO₄
 MgSO₄
 ug
 TIW
 AS
 AD
 AU
 OS
 OD
 OU

Medications – 3 Hour Bundle

INSTRUCTIONS: Administer antibiotics within 1 hour from time of presentation (after blood culture is drawn)
 Add additional antibiotics as needed for clinical picture
 Administer appropriate broad spectrum antibiotics: **Monotherapy** or **Combination** Therapy

Monotherapy

Cefepime 2g IV Q8H X 48hrs (if meningitis is suspected)

Levofloxacin (Levaquin) 750 mg IV Q24H X 48hrs

Zosyn 3.375g IV Q6H X 48hrs

Criteria to add vancomycin where MRSA is known or suspected:

Central venous catheter or other indwelling hardware in place

Recent (within 3 months) or current prolonged hospitalization > 2 weeks

Transfer from a nursing home or subacute facility

On Chronic Dialysis

IV drug use

Vancomycin 1g/200mL IV Q12H X 48hrs

Combination therapy include: aztreonam 2 gm and vancomycin 1gm or ciprofloxacin 400mg and vancomycin 1gm

Aztreonam (Azactam) 2 g IV Q8H X 48hrs

Ciprofloxacin (Cipro) 400mg/200mL IV Q12H X 48hrs

Vancomycin 1g/200mL IV Q12H X 48hrs

Time Order Scanned: _____

Trailing
 zero after
 whole
 number
 (i.e. 5.0 mg)

MUST USE
 the following
 abbreviation:

Leading zero
 before a less
 than whole
 number
 (i.e. 0.5 mg)

Physician Signature: _____ Name (Print): _____ Date/Time: _____ Pager: _____

Nurse Signature: _____ Name (Print): _____ Date/Time: _____

US Signature: _____ Name (Print): _____ Date/Time: _____

HU HOWARD
 UNIVERSITY
 HOSPITAL

**SEVERE SEPSIS / SEPTIC SHOCK
 ORDER SET –
 3 Hour
 Bundle**



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DIAGNOSIS: _____

NO KNOWN ALLERGIES

ALLERGY and MEDICATION
 SENSITIVITY INFORMATION
 (Transfer to each new order)

AGE: _____ WT.: _____ HEIGHT: _____

ORDERED DATE / TIME **Severe Sepsis / Septic Shock Order Set – 3 Hour Bundle**

DO NOT USE the following abbreviations:

Antibiotic List for ED only

- U
- IU
- QD
- QOD
- MS
- MSO₄
- MgSO₄
- ug
- TIW
- AS
- AD
- AU
- OS
- OD
- OU

<input type="checkbox"/> Aztreonam (Azactam) 2 g IV One Time
<input type="checkbox"/> Cefepime 2g IV One Time
<input type="checkbox"/> Ciprofloxacin (Cipro) 400mg/200 D5W IV ONE TIME
<input type="checkbox"/> Levofloxacin (Levaquin) 750mg IV PB One Time
<input type="checkbox"/> Vancomycin (Vancocin) 1g IV One Time
<input type="checkbox"/> Zosyn 3.375 g IV One Time

INSTRUCTIONS: If patient's condition progress to Septic Shock, initiate Severe Sepsis / Septic Shock – 6 Hour Bundle Orderset

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Trailing zero after whole number (i.e. 5.0 mg)

MUST USE the following abbreviation:

Leading zero before a less than whole number (i.e. 0.5 mg)

Time Order Scanned: _____

Physician Signature: _____ Name (Print): _____ Date/Time: _____ Pager: _____
 Nurse Signature: _____ Name (Print): _____ Date/Time: _____
 US Signature: _____ Name (Print): _____ Date/Time: _____



SEVERE SEPSIS / SEPTIC SHOCK ORDER SET – 3 Hour Bundle



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ORDERED
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Severe Sepsis / Septic Shock Order Set – 6 Hour Bundle

**DO NOT USE
 the following
 abbreviations:**

Diagnostics – 6 Hour Bundle

**INSTRUCTION: Repeat Lactic acid level must be done within 6 hours of
 Severe Sepsis / Septic Shock presentation**

Perform I-STAT Lactate level Stat

Lactic Acid Stat Repeat if 1st Lactate is > 2 (18 mg/L) &/or not previously resulted

Medications – 6 Hour Bundle

**INSTRUCTIONS: Order vasopressors if tissue hypo-perfusion persists in the hour after
 crystalloid fluid is administered at 30ml/kg as evidenced by either:**

SBP < 90 mmHg

MAP < 65 mmHg

Decrease in SBP by 40 mmHg from last recorded SBP considered normal for patient

ADDITIONAL REMINDERS:

Norepinephrine is the first line agent

If additional vasopressor support is needed, add or switch to EPINEPHrine

Use phenylephrine only for norepinephrine associated with serious arrhythmias,
 high cardiac output with persistently low BP

Vasopressin max = 0.03 units/minute and should not be used as a single agent;
 higher doses should be reserved for salvage therapy

Norepinephrine (Levophed) 8 mg/250 mL IV, 2 mcg/min

Epinephrine 2 mg/250 mL IV, 1 mcg/min

Phenylephrine 10 mg/250 mL NS IV Continuous, Titrate as directed

Vasopressin 20 Units/100 mL IV Drip @ 0.03 units/min

Time Order Scanned: _____

Physician Signature: _____ Name (Print): _____ Date/Time: _____ Pager: _____

Nurse Signature: _____ Name (Print): _____ Date/Time: _____

US Signature: _____ Name (Print): _____ Date/Time: _____



**SEVERE SEPSIS / SEPTIC SHOCK
 ORDER SET –
 6 Hour
 Bundle**



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DIAGNOSIS: _____

NO KNOWN ALLERGIES

ALLERGY and MEDICATION SENSITIVITY INFORMATION <i>(Transfer to each new order)</i>	
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AGE: _____ WT.: _____ HEIGHT: _____

	ORDERED	
	DATE / TIME	
DO NOT USE the following abbreviations: U IU QD QOD MS MSO ₄ MgSO ₄ ug TIW AS AD AU OS OD OU & Trailing zero after whole number (i.e. 5.0 mg)		<input checked="" type="checkbox"/> Severe Sepsis / Septic Shock Order Set – 6 Hour Bundle
		<i>Monitoring – 6 Hour Bundle</i>
		INSTRUCTION: LIP must document all FIVE assessments one hour after Crystalloid administration
		<input checked="" type="checkbox"/> Stat Check Vital Signs and Temperature (RN)
		<input checked="" type="checkbox"/> Stat Check Capillary Refill (RN)
		<input checked="" type="checkbox"/> Stat Perform Skin Examination (RN)
		<input checked="" type="checkbox"/> Stat Perform Peripheral Pulse Check (RN)
		<input checked="" type="checkbox"/> Stat Call LIP to confirm and document above nursing assessments
		<input checked="" type="checkbox"/> Stat Call LIP to perform and document Cardiopulmonary Examination
		<i>OR Any TWO of the following:</i>
		<input type="checkbox"/> Stat Central Venous Pressure Measurement (RN)
		<input type="checkbox"/> Stat Central Venous Oxygen Measurement (RN)
		<input type="checkbox"/> Stat Passive Leg Raise (RN)
		<input type="checkbox"/> Echo Without Doppler Complete to be done at bedside Stat
	<input type="checkbox"/> Stat Fluid Challenge (RN)	
MUST USE the following abbreviation: Leading zero before a less than whole number (i.e. 0.5 mg)		**** End of Severe Sepsis / Septic Shock Orderset – 6 Hour Bundle ****
		<i>Time Order Scanned:</i> _____

Physician Signature: _____ Name (Print): _____ Date/Time: _____ Pager: _____
 Nurse Signature: _____ Name (Print): _____ Date/Time: _____
 US Signature: _____ Name (Print): _____ Date/Time: _____



SEVERE SEPSIS / SEPTIC SHOCK ORDER SET



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