Alberta Health Services

Cutover Non-Medication Orders

(Continuing Care/Hospice/Palliative)

These orders will go into effect at launch on the day of Connect Care implementation.

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Do not use this form for orders to be acted on immediately. **If sections of this form do not apply** to the patient, strike through that section. If any clarification is required regarding the information on these sheets, the attending physician will be contacted (NMO).

The NMO can be revised and added to until backload is completed. Medication review is to be completed on the Patient Medication Profile at the same time. If new or revised named orders are required after backload, these would be completed on the "pink" sheet and entered into Connect Care after launch by the frontline team.

	Admin Use Only Entry Complete?	
Date of Cutover *(dd-Mon-yyyy)*	**Yes**	**No**
Most Responsible Provider *(print name)*		
Problem List	**Yes**	**No**
Principal problem _____ Other problems _____ _____ _____ _____		
Goals of Care	**Yes**	**No**
Goals of Care Status ☐R1 ☐R2 ☐R3 ☐M1 ☐M2 ☐C1 ☐C2 Has the GCD been ordered after relevant conversation with patient or alternate decision maker? ☐ Patient ☐ Alternate Decision Maker ☐ No, this is an interim order prior to conversation. Has this decision been part of a dispute process? ☐ Yes ☐ No		
Patient's location of care where this GCD order was ordered: ☐ Home ☐ Clinic/Facility/Hospital		
Clarifications to this GCD order _____ _____		
Visitation Status	**Yes**	**No**
☐ Restricted Visitation status *(specify type of restricted visitation)* ☐ Resident may have unlimited social leaves ☐ Resident needs to attend social leaves with *(specify name)* _____ ☐ Passes		
Implantable Cardioverter Defibrillator	**Yes**	**No**
Nursing Communication – Deactivate ICD ☐ Deactivate ICD *(Implantable Cardioverter Defibrillator)* as discussed with Patient/Alternative Decision Maker		

Physician Name *(print)*	**Physician Signature**	Date *(dd-Mon-yyyy)*	Time *(hh mm)*

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	Admin Use Only Entry Complete? Yes	No
Diet and Nutrition	**Yes**	**No**
☐ Total Fluid Intake (TFI)		
Patient Care	**Yes**	**No**
Precautions and Safety *(Hospice/Palliative Requirement):* ☐ Seizure Precautions and Monitoring as per unit policy ☐ Nursing Communication- Braden Scale Monitoring as per unit policy *(palliative/hospice only)* ☐ Nursing Communication- May put up all 4 side rails. *Follow restraint monitoring as per policy.* ☐ Nursing Communication- complete a Managed Risk Agreement as required. *(e.g. eating at risk, mobilization)*		
Activity *(level of physical activity restrictions for resident)*	**Yes**	**No**
☐ No activity restrictions ☐ Activity *(specify)* _____		
Vital Signs	**Yes**	**No**
☐ Vital Signs Per Protocol ☐ Vital Signs, every 2 months ☐ Nursing Communication- Assess Vital Signs *(temperature, blood pressure, heart rate)* every _____ months ☐ Pulse Oximetry daily for 3 days ☐ No Vital Signs		
Point of Care Testing Glucose	**Yes**	**No**
Diabetes Canada Guidelines ☐ Glucose Meter POCT- Before Meals and Bedtime. 4 times daily before meals and at bedtime, 15 to 30 minutes before scheduled meals and at bedtime, AND PRN for suspected hypoglycemia ☐ Glucose Meter POCT- Daily at night *(0200 hours)* ☐ Glucose Meter POCT- 3 times daily after meals, Assess 2 hours post meal time ☐ Glucose Meter POCT Other *(specify)* _____ ☐ Notify Most Responsible Healthcare Provider- Blood Glucose Targets. *If blood glucose is less than 4.0 mmol/L initiate AHS Hypoglycemia Policy and contact authorized Prescriber. If blood glucose is greater than 18.0 mmol/L OR if patient on insulin pump SGLT2 inhibitors and blood glucose is greater than 14.0 mmol/L initiate hyperglycemia Procedure, and notify Authorized prescriber and collect ketones.*		
Patient Care Assessments	**Yes**	**No**
☐ Nursing Communication: Nursing to complete skin assessment ☐ Nursing Communication: Nursing to complete Behavior Mapping daily for 2 weeks		

Physician Name *(print)*	**Physician Signature**	Date *(dd-Mon-yyyy)*	Time *(hh mm)*

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	Admin Use Only Entry Complete?	
Patient Care Interventions (Hospice)	**Yes**	**No**
☐ Nursing Communication- May consume alcohol *(alcohol is stored as per unit policy/practice)*		
☐ Oral Care per protocol. Mouth care every _____ hour(s)		
☐ Nursing Communication- Eye care every _____ hour(s)		
☐ Insert Foley Catheter		
☐ Urinary Catheter Care- Change per unit protocol		
☐ Urinary catheter care- Irrigate PRN with 50 mLs of normal saline		
☐ Urinary Catheter care- lidocaine 2% gel, apply intra-urethral once PRN, for catheter insertion		
☐ Bladder Scan- as needed		
☐ In and Out Catheter- PRN, when required if patient unable to void		
☐ Urinary Catheter- Discontinue, once		
Respiratory Interventions	**Yes**	**No**
☐ O2 therapy- Current oxygen needs for patient comfort		
☐ Oxygen Therapy: Titrate Oxygen to maintain saturation range at or above 89%		
☐ Nursing Communication- Place patient in upright position *(45 degree incline)*		
☐ Nursing Communication- provide fan for dyspnea following organization's infection control practices guidelines		
Procedures	**Yes**	**No**
☐ Ear Cerumen Removal POC once - *Administer 2 drops of olive or mineral oil to affected ear(s) daily at bedtime for 5 days consecutively prior to flushing ears. Ear flushing procedure to be completed in accordance with the site practice every 10 days PRN*		
☐ Ear Cerumen Removal POC once – *If ear wax was not successfully removed after initial flushing, nursing team may repeat procedure. Repeat flushing should not occur sooner than 10 days from initial flushing. If clinician is still unsuccessful after repeating procedure or if the condition persists for greater than 5 days, Contact Authorized Prescriber*		
☐ Ear Cerumen Removal as per site protocol		
Labs (0700-2359 hours) ONLY. Time: 1400 hours	**Yes**	**No**
Hematology		
☐ CBC and Differential, Date for draw/collection: _____		
Coagulation		
☐ INR, Date for draw/collection: _____		
☐ Partial Thromboplastin Time (PTT), Date for draw/collection: _____		

Physician Name *(print)*	**Physician Signature**	Date *(dd-Mon-yyyy)*	Time *(hh mm)*

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	Admin Use Only Entry Complete?	
Labs (0700-2359 hours) ONLY. Time: 1400 hours - *continued*	**Yes**	**No**
General Chemistry ☐ Blood Gas, Arterial, Date for draw/collection: _____ ☐ Calcium, Date for draw/collection: _____ ☐ Calcium, Ionized, Date for draw/collection: _____ ☐ Creatine Kinase (CK), Date for draw/collection: _____ ☐ Lipase, Date for draw/collection: _____ ☐ Magnesium, Date for draw/collection: _____ ☐ Phosphate, Date for draw/collection: _____ ☐ Troponin, Date for draw/collection: _____		
Electrolytes ☐ Ammonia, Date for draw/collection: _____ ☐ Urea, Date for draw/collection: _____ ☐ Creatinine, Serum, Date for draw/collection: _____ ☐ Electrolyte Panel, Date for draw/collection: _____		
Diabetes Monitoring ☐ Glucose, Random, Date for draw/collection: _____ ☐ Hemoglobin A1c, Date for draw/collection: _____		
Thyroid Function ☐ TSH, Date for draw/collection: _____		
Other *(please indicate the date of next draw/collection for the lab)*		
Other Non-Medication Orders *(please specify)*	**Yes**	**No**

Physician Name *(print)*	**Physician Signature**	Date *(dd-Mon-yyyy)*	Time *(hh mm)*
Cutover Nurse Name *(print)*	**Cutover Nurse Signature**	Date *(dd-Mon-yyyy)*	Time *(hh mm)*