### POST-OPERATIVE CESAREAN SECTION ORDERS 1 of 4

<table>
<thead>
<tr>
<th>ORDER TYPE</th>
<th>ORDER DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSFER TO MBU</strong></td>
<td><strong>When recovery criteria met</strong></td>
</tr>
<tr>
<td><strong>1. NEONATAL RESUSCITATION</strong></td>
<td></td>
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<tr>
<td>- Requested Advanced Skills Neonatal Resuscitation at Delivery</td>
<td></td>
</tr>
<tr>
<td><strong>2. VITAL SIGNS AND ASSESSMENT</strong></td>
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<tr>
<td>- Monitor vital signs every 15 minutes x 2 hours or as needed until transfer.</td>
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<tr>
<td></td>
<td>- Transfer if stable. Obtain vital signs and complete assessment upon admission to MBU and every 4 hours x 48 hours (may omit 0400 if patient stable), then every 8 hours while awake and as needed until discharge.</td>
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<tr>
<td><strong>3. DIET</strong></td>
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<tr>
<td>- Clear liquid and advance as tolerated</td>
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<tr>
<td></td>
<td>- Ice chips only</td>
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<tr>
<td></td>
<td>- Nothing by mouth</td>
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<tr>
<td></td>
<td>- Regular diet</td>
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<tr>
<td><strong>4. ACTIVITY</strong></td>
<td></td>
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<tr>
<td>- Bathroom with assistance until motor/neuro stability, then activity as tolerated.</td>
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<tr>
<td>- Postpartum therapeutic exercise instruction.</td>
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<tr>
<td><strong>5. AIRWAY MANAGEMENT</strong></td>
<td></td>
</tr>
<tr>
<td>- Encourage deep breathing and coughing every 1 hour while awake for first 24 hours post-operatively</td>
<td></td>
</tr>
<tr>
<td>- Incentive spirometer</td>
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<tr>
<td><strong>6. INTRAVENOUS (IV) HYDRATION</strong></td>
<td></td>
</tr>
<tr>
<td>- Lactated Ringers with 5% Dextrose at ________ mL/hour</td>
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</tr>
<tr>
<td></td>
<td>- Lactated Ringers at ________ mL/hour</td>
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<tr>
<td></td>
<td>- __________________________ at ________ mL/hour</td>
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<tr>
<td>- May convert to intermittent infusion device when patient condition warrants</td>
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<tr>
<td><strong>7. INTAKE AND OUTPUT</strong></td>
<td></td>
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<tr>
<td>- Monitor intake &amp; output every shift. Discontinue when tolerating by mouth, intravenous discontinued, and voiding every shift.</td>
<td></td>
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<tr>
<td><strong>8. URINARY BLADDER CATHETERIZATION</strong></td>
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<tr>
<td>- Indwelling urinary catheter to gravity drainage. Discontinue if urine clear 12-24 hours.</td>
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<tr>
<td><strong>9. LABS</strong></td>
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<tr>
<td>- Complete Blood Count (CBC) first postpartum day</td>
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</table>

**ALLERGIES:**

Refer to Allergy Profile/Powerchart

**TRANSPORT TO MBU:**

When recovery criteria met

(✓) Check, circle and/or fill in all orders to be implemented as appropriate.

- Requested Advanced Skills Neonatal Resuscitation at Delivery
- Monitor vital signs every 15 minutes x 2 hours or as needed until transfer. Transfer if stable. Obtain vital signs and complete assessment upon admission to MBU and every 4 hours x 48 hours (may omit 0400 if patient stable), then every 8 hours while awake and as needed until discharge.
- Clear liquid and advance as tolerated
- Bathroom with assistance until motor/neuro stability, then activity as tolerated.
- Encourage deep breathing and coughing every 1 hour while awake for first 24 hours post-operatively
- Complete Blood Count (CBC) first postpartum day

___

Initials

KH00166 Rev. 01/09/12
10. MEDICATIONS

A. MEDICATIONS FOR SELF ADMINISTRATION (SAMS)

☐ Patient receives all medications below:

- Docusate Sodium with Senna (Pericolace/Senokot-S) 2 capsules/tablets by mouth every evening as needed for constipation
- Ibuprofen 400 mg by mouth with food or milk every 6 hours as needed for mild pain
- Ibuprofen 600 mg by mouth with food or milk every 6 hours as needed for moderate pain
- Ibuprofen 800 mg by mouth with food or milk every 6 hours as needed for severe pain

* Ibuprofen dosage should not exceed 3200 mg in a 24 hour period

* Replace Ibuprofen with Acetaminophen 325 mg 3 tabs (975 mg) by mouth every 4 hours as needed for pain in Non-Steroidal Anti-Inflammatory Drug (NSAID)/Aspirin sensitive patients (not to exceed 4 doses in 24 hours)

B. NEW MEDICATIONS

Pain Medication

☐ Ketorolac (Toradol) 30 mg intravenous every 6 hours for 24 hours
☐ Oxycodone/Acetaminophen (Percocet) 5/325 mg by mouth every 4 hours as needed (moderate)
☐ Oxycodone/Acetaminophen (Percocet) 10/650 mg by mouth every 4 hours as needed (severe)

<table>
<thead>
<tr>
<th>Other Pain Medication</th>
<th>dose</th>
<th>route</th>
<th>interval</th>
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<tbody>
<tr>
<td>a.</td>
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<tr>
<td>b.</td>
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<tr>
<td>c.</td>
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Nausea Medication

☐ Metoclopramide (Reglan) 10 mg intravenous every 6 hours as needed
☐ Metoclopramide (Reglan) 10 mg by mouth every 6 hours as needed
☐ Ondansetron (Zofran) 4 mg intravenous every 6 hours as needed
☐ Simethicone (Mylicon) 80 mg by mouth after meals and at bedtime as needed

RH Immune Globulin (Rhlg) Prophylaxis

☐ Fetal Screen if Rh negative
☐ Administer one vial Rhlg intramuscular if indicated per protocol

Rubella Vaccine

☐ Rubella Non-immune: Administer Rubella vaccine 0.5 mL subcutaneous prior to discharge

IV/Uterine Bleeding Prophylaxis

☐ Methylergonovine (Methergine) 0.2 mg intramuscular every 6 hours as needed x _____ dose(s)

- Hold if blood pressure is greater than __________ mmHg

☐ Methylergonovine (Methergine) 0.2 mg by mouth every 6 hours as needed x _____ dose(s)

- Hold if blood pressure is greater than __________ mmHg

☐ Oxytocin 20 units/1,000 mL Lactated Ringers x ________ liters. Infuse ________ mL at ________ mL/hour

Initials________________
### POST-OPERATIVE

**CESAREAN SECTION ORDERS 3 of 4**

(✓) Check, circle and/or fill in all orders to be implemented as appropriate.

<table>
<thead>
<tr>
<th>Sleep Medication</th>
<th>dose</th>
<th>route</th>
<th>interval</th>
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<th>Infection Medication</th>
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<th>interval</th>
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**C. DEEP VEIN THROMBOSIS (DVT) PROPHYLAXIS (Risk Assessment on Back)**

**REQUIRED to (✓) check all that apply:**

- [ ] Heparin 5000 units subcutaneous every 8 hours
- [ ] Pneumatic Compression Device (PCD) for Knee High/Calf Pump
- [ ] Other Orders: ____________________________
- [ ] DVT Prophylaxis not indicated/contraindicated (Reason): ____________________________

**D. IMMUNIZATIONS**

- [ ] Offer Tdap vaccine (tetanus diphtheria pertussis) 0.5 mL intramuscular x 1 for prophylaxis (contraindicated in patients who have previously received the Tdap vaccine)
- [ ] Per New York State Department of Health (NYS DOH) Mandatory Immunization Program and Kaleida Policy CL.6, administer vaccine(s) if patient meets criteria.
  - **Pneumococcal Vaccine 0.5 mL intramuscular x 1 for prophylaxis**
    - If contraindicated please (✓) check one of the NYS DOH acceptable contraindications below:
      - [ ] Allergy to pneumococcal vaccine
      - [ ] Previously immunized
      - Date: ____________________________

  - **Influenza Vaccine 0.5 mL intramuscular x 1 for prophylaxis** (September 1 - April 1)
    - If contraindicated please (✓) check one of the NYS DOH acceptable contraindications below:
      - [ ] Allergy to influenza vaccine
      - Date: ____________________________

**11. MISCELLANEOUS**

- [ ] Abdominal binder

**12. ADDITIONAL ORDERS**

- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________

**TORB**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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**NURSING**

<table>
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<th>Date:</th>
<th>Time:</th>
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**ORDERED BY RN**

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<th>Date:</th>
<th>Time:</th>
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**ORDERED**

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<th>Date:</th>
<th>Time:</th>
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**Provider**

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<tr>
<th>Date:</th>
<th>Time:</th>
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**Print Name/Stamp:** ____________________________

**Signature:** ____________________________

**TORB = Telephone Orders Read Back**
Patient Name

Date of Birth

Admission/Visit Date

Site

Medical Record Number

Financial Number

Patient read Vaccine Information Sheet (KH01159)

• Patient consented - patient/health care proxy signed Vaccine Information Sheet. Form scanned to pharmacy for vaccine dispensing.

• Patient refused and reason stated

• Received pneumococcal vaccine at age 65 or greater. If date unknown, revaccinate.

• Received pneumococcal vaccine at age 65 or less, wait 5 years to revaccinate. If date unknown, revaccinate.

• Previous severe reaction to pneumococcal vaccine (urticaria, laryngeal edema, anaphylaxis)

CONSENTS:

PNEUMOVAX

(must be administered year round)

Patient Name

Date of Birth

Admission/Visit Date

Site

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Patient ID Area

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NEW YORK STATE DEPARTMENT OF HEALTH LAW SECTION 2805-8, CHAPTER 443:

• Every in-patient must be assessed for pneumococcal and influenza vaccine need

• Standing Physician Order for all in-patients, signed by Dr. Margaret Paroski, EVP CMO

IMMUNIZATION

CRITERIA

INDICATIONS for BOTH PNEUMOVAX and INFLUENZA:

• Age 65 or greater

• Age greater than 18 with chronic illnesses such as diabetes, asthma, emphysema, pneumonia, congestive heart failure, coronary artery disease, chronic renal failure, immunosuppression

• If previous vaccination unknown, and criteria met, revaccinate

• NO VACCINATION INDICATED if patient is between 18 and 65 years old, without chronic illness

CONTRAINDICATIONS:

PNEUMOVAX

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• Received pneumococcal vaccine at age 65 or less, wait 5 years to revaccinate. If date unknown, revaccinate.

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INFLUENZA

(Flu season is September 1 - April 1, as vaccine available from pharmacy)

• Received vaccine earlier THIS flu season. If unknown, revaccinate

• History of allergic reaction to eggs or contact lens solution (Thimerosal - preservative in solution)

• Previous severe reaction to influenza vaccine (urticaria, laryngeal edema, anaphylaxis)

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