STANDING ORDERS for SKILLED NURSING FACILITIES

Minnesota Association of Geriatric Inspired Clinicians (MAGIC), Alliance for Clinical Excellence (ACE)

Revised for 2024

The following standing orders apply to patients in skilled nursing facilities, including Long-Term Care and Transitional Care Units. These orders have been compiled by a professional group of clinicians who are members of MAGIC. The medical director of each facility, in coordination with the facility clinical leaders, will review and approve these standing house orders.

Prior to initiating medication orders, review the patient's current medication list and allergies. All orders initiated from standing orders should be communicated to the provider.

Admission to Facility

- Long-Term Care:
  - Obtain weekly vital signs (TPR, BP, O2, weight) for four weeks, then monthly thereafter unless directed otherwise.
  - May see audiologist, dentist, podiatrist, optometrist, psychology prn. Notify provider of psychology referral.
- Transitional Care/Short-Stay:
  - Daily vital signs (TPR, BP, and O_2 saturation) unless directed otherwise.
  - Weekly weights for patients without Heart Failure unless directed otherwise.
  - Physical Therapy, Occupational Therapy, and/or Speech Therapy to evaluate and treat as indicated.
- Orthostatic BP, HR upon admission and monthly for patients on antipsychotic medications
- Heart Failure Management
  - Daily weights for patients with Heart Failure unless directed otherwise.
  - Call for weight gain 3 pounds or greater in 24 hours or 5 pounds in one week weight unless directed otherwise.
  - Assess lung sounds, peripheral edema, and respiratory effort daily unless directed otherwise.
- Administer facility-specific cognitive screening tests.
- May participate in therapeutic recreation activities without restrictions unless directed otherwise.
- Activity level as tolerated unless otherwise ordered.
- TB screening available options:
  - Administer two-step Mantoux (preferred method)
  - If history of positive PPD and/or Mantoux is contraindicated due to history of TB or allergy to Mantoux, obtain one of the following tests (per facility protocol). Notify provider only if results are abnormal.
    - QuantiFERON-TB Gold (QFT-G) blood test
    - Chest X-ray (CXR) within the past 3 months of admission to the facility. Obtain a copy of the CXR report to document the patient's status. Radiology report must report no TB or cavitary lesions. If no CXR is available, obtain a CXR within 72 hours of admission.
  - Alternate option to Mantoux: One-step QuantiFERON-TB Gold (QFT-G) blood test
    - If positive or indeterminate results, obtain CXR. Notify provider only if CXR results are abnormal.

Immunizations and Testing

- Per CDC guidelines, administer COVID-19 vaccine upon admission and per recommended schedule, unless contraindicated.
- Complete COVID-19 PCR or antigen testing as indicated for outbreak and/or routine testing per facility policy.
- Per CDC guidelines, administer influenza vaccine annually in autumn and/or to patients who have not already received it unless contraindicated.
  - Refer to MAGIC's Influenza Protocol for testing, treatment, and chemoprophylaxis orders. Also consult CDC guidelines and notify the medical director when an influenza outbreak is confirmed.
- Per CDC guidelines, administer pneumococcal vaccinations unless contraindicated.
- LTC: Per CDC guidelines, substitute a 1-time dose of Tdap for Td booster, then boost with Td every 10 years.

Needle Stick

- For needle stick or body fluid exposure, facility has permission to draw Hepatitis Panel and HIV blood tests.

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Anticoagulation

- For all patients on warfarin, draw an INR the day after admission unless the admission orders specify otherwise.
- Call INR results to provider or institute the facility Coumadin management service (CAMP) if available during business hours.
- If an antibiotic is started, check INR within 3 days if the patient is on warfarin.

Cardiovascular

- Nitroglycerin 0.4 mg SL prn for chest pain or other signs/symptoms of acute angina; may repeat q 5 minutes x 2
- If chest pain/acute angina is not relieved after two doses of nitroglycerin, unless contrary to advance directives call 911; notify provider immediately.

Suspected or Known Narcotic Overdose

- If suspected or known narcotic overdose, administer 0.4mg of Naloxone (Narcan) IM or 4mg/0.1ml nasal spray as a single dose in one nostril; may repeat dose every 2-3 minutes. Call 911.

Comfort

- Acetaminophen 650 mg PO q 6 hours prn for pain/fever (acetaminophen not to exceed 3 grams per 24 hours) x 3 days (additional orders/longer duration needs to be received from PCP).
    - Notify provider for any new fever episode > 101.3˚ or for temperature > 2˚ above patient's baseline.
- Cepacol or therapeutic equivalent (regular or sugar free) 1 lozenge dissolved in mouth q 2 hours prn for sore throat x 3 days; contraindicated in dysphagia.
- Cough Drop 1 lozenge dissolved in mouth q 2 hours PRN for cough x 3 days; contraindicated for dysphagia.
- Apply ice/cold pack for 20 min qid prn to injuries with inflammation.
- Preparation H or Anusol ointment (or therapeutic equivalent) per package instructions qid prn after bowel movement for hemorrhoid pain x 3 days.
- Lidocaine 1% 2.1 mL as a diluent with IM Rocephin prn for local anesthesia.
- Artificial tear formulation 2 drops qid prn to affected eye(s) x 3 days.
- Anti-dandruff shampoo 2 days/week prn for dry scalp if desired.
- Aromatherapy per facility policy.

Diet

- When specific diet orders are not present, the nurse or dietitian may initiate a diet that conforms to the facility's dietary options and best meets the patient's needs. If there are questions or concerns with initiating an appropriate diet, call the provider to clarify.
- Qualified dietician, nutrition professional, speech therapist has been delegated the task of writing dietary orders consistent with state and federal guidelines.
- The nurse or dietician may change diet to an equivalent facility diet.
- If patient has a feeding tube:
    - Water Flush: Flush feeding tube with 150 cc water every 8 hours unless otherwise ordered.
    - Medication Administration: Flush tube with 30 ml water before and after administering each medication. Flush with 60 ml water after all medications have been administered and upon completion of enteral feeding.
- For occluded G-tubes, may use a G-tube declogger device or proceed with facility protocol.
    - Instill warm water into the enteral access device (EAD) using a 30 or 60-mL syringe and apply a gentle back-and-forth motion with the plunger of the syringe.
    - If water flush does not resolve the clog, use an uncoated pancreatic enzyme solution by crushing one uncoated pancreatic enzyme tablet and one 325-mg sodium bicarbonate tablet mixed in 5 mL of water. The solution should be introduced to the clog and clamp the feeding tube for at least 30 minutes. If the clog is not cleared within 30 minutes, the solution should be removed from the tube and replaced with a fresh mixture.
    - If water flush does not resolve the clog, use an enzyme containing declogging kit or mechanical declogging device.
- Calorie/protein supplements per dietician/nursing as needed.
- Regular diet prn for special occasions per nurse/dietician discretion; maintain ordered texture or thickened liquids
- Unless contraindicated, 1 alcoholic beverage (12 oz. beer, 5 oz. wine or 1 oz. liquor in mixed drink) prn for social events at the nurse's discretion.

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Medications

- Medications may be crushed or given in liquid form unless contraindicated or otherwise specified.
- For prn medications in which dosing quantity (e.g., # of tablets, dosing interval) is not singular or specific.
    - Always use the shortest interval of time ordered.
    - Administer 1 dose for severity rated 1-5/10; 2 doses for severity rated 6-10/10.
- If condition warrants patient may go on a therapeutic leave of absence prn with scheduled medications in non-child proof containers per healthcare coverage with resident/responsible party signing release of responsibility
- Initiate self-administration of medication (SAM) evaluation after patient expresses desire to self-administer their medications and demonstrates ability to safely self-administer specific medication(s)
- May adjust medication administration times for special events/patient request.
- Discontinue prn orders for antipsychotic medications after 14 days and call provider with an update.
- Unless a longer duration is specified, discontinue prn orders for antidepressants, anxiolytics, and hypnotics after 14 days and call provider with an update.

Respiratory

- Guaifenesin 400 mg [tablet or 100mg/5ml liquid] PO q 4 hours prn (expectorant) x 3 days
- Albuterol 2.5 mg/3mL NEB x one dose prn for dyspnea or wheezing; update provider with nursing assessment.
    - Do not administer nebulizer if any concern for COVID-19.
- Initiate and titrate supplemental O_2 from 1-4 L/min via nasal cannula prn for dyspnea, hypoxia (O_2 saturation < 90% or <88% for COPD) or acute angina to keep O2 saturations >90%; immediately update provider with nursing assessment.
- May wean supplemental O_2 per nursing judgment to maintain O_2 saturation > 90%; monitor O_2 saturations tid x 3 days after O_2 is discontinued, including one O_2 saturation during night-time sleep.
- In patients with a tracheostomy, initiate trach care per facility protocol, suction prn and use a trach dome when O_2 is indicated.

Diabetic Management

- Initiate qid blood glucose monitoring upon admission x 3 days for ALL diabetic patients unless ordered otherwise.
- If DMII: Notify provider if two BG results are < 70 or > 400 in a 24-hour timeframe and/or change in condition; if no condition change, notify provider on the next business day
- If DMI notify the provider if any BG results are < 70 or > 400 and/or change in condition
- Unless specified otherwise, no sliding scale insulin coverage at HS.

Hypoglycemia (BG <70)

- If patient is symptomatic, conscious, and able to swallow or has a feeding tube:
    - Administer 6 oz. fruit juice, milk, other high carbohydrate beverage (e.g., Ensure, Boost), or glucose tabs or gel orally or via feeding tube.
    - Repeat BG after 15 minutes; if < 70, repeat above intervention.
    - If after 2 attempts to treat and BG is still < 70, notify provider.
- If patient is unresponsive or unable to swallow and does not have a feeding tube:
    - Administer Glucagon 1 mg IM.
    - Repeat BG after 10 minutes; if < 70 and patient still unresponsive, repeat Glucagon.
    - After giving second Glucagon dose, if patient is still unresponsive, unless contrary to advance directives - call 911 and notify provider immediately.
    - If BG remains < 70 but patient is conscious, initiate interventions for the conscious patient.
- Once patient is stable, recheck BG after 60 minutes.
- Communicate occurrence of any hypoglycemic event to provider the next business day.

Indigestion

- Calcium carbonate 500 mg 1 tab PO (chewable) qid prn x 3 days or
- Liquid antacid (facility stock) 30 mL PO qid prn x 3 days.
    - **Note:** do not use magnesium-based products in patients with renal failure.

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Diarrhea (Perform steps sequentially)

1. Perform rectal check to determine if impaction is present.
   - If impacted, follow guidelines for constipation.
   - If not impacted, hold all cathartic-related (constipation) meds, and observe for 24 hours.
2. If diarrhea resolves, resume cathartic-related (constipation) meds.
3. If diarrhea continues:
   - Notify provider of the change in condition to determine if testing for C. difficile toxin A and B is indicated.
   - If testing for C. difficile toxin is ordered, collect only liquid stool (formed stool will not be tested)
   - Maintain hydration.

Constipation (Perform steps sequentially)

1. Consider rectal check to determine if impaction is present.
2. Encourage 2,000 ml daily fluid intake unless contraindicated.
3. Consult nutrition services for dietary recommendations.
4. Sennoside 8.6 mg, take 2 tablets PO at HS prn x 3 days.
5. Bisacodyl suppository 10 mg PR daily prn x 3 days.
6. Reattempt Senna or Bisacodyl if no results after 24 hours and notify provider.
7. Monitor and record results from treatment.

Bladder

- Bladder scan PRN for no void in 8 hours, or suprapubic pain, bladder spasms, or urgency.
  - Straight cath prn for post void residual > 250 mL on bladder scan.
  - If bladder scanner is unavailable, straight cath for residual and notify the provider.
- If there is an order to remove a Foley catheter, use the following protocol after removing the catheter:
  - Assess voiding q 8 hours and PRN for discomfort with bladder scan or history x 24 hours.
  - Straight catheterize q 8 hours prn for post void residual > 250 mL on bladder scan, no voiding in 8 hours, full bladder on palpation, or if the patient is uncomfortable, and notify provider next business day.
  - If requiring straight cath x 3 in 24 hours, replace foley catheter and notify provider next business day.
  - If requiring straight cath 1-2x in 24 hours or if persistent urinary symptoms, continue to assess voiding q 8 hours with bladder scan x 24 hours, and notify provider next business day.
  - May use lidocaine jelly 2% catheter lubricant prn for local anesthesia with straight cath.
- Care of indwelling catheter
  - Do not irrigate.
  - Change catheter prn for leaking or decreased urinary output using a similar-sized catheter.
  - Change catheter and tubing prior to obtaining sample for UA/UC.
  - May attach leg bag when patient is out of bed; reattach to straight drainage when in bed.

Sleep

- Institute a 3-day sleep record if the patient is complaining of difficulty sleeping if able

Cerumen

- Debrox or mineral oil 3 drops to affected ear at bedtime x 3 days.
- Gently irrigate affected ear canal with tepid water on the 4th day.
- Repeat x 1 if indicated and update provider.

IV Line Management

- Initiate routine IV line and site care per facility protocol.
- May replace peripheral line per facility protocol or prn for site infiltration or phlebitis.
- May discontinue peripheral IV line if no indication for use.
- Do not remove PICC or central lines without an order from provider.

Falls

- Fall with no injury: notify provider during business hours, including the next business day if fall occurs during non-business hours. On-call providers do not need to be notified of fall without injury or concern.

Skin and Wound Management

- Institute facility wound management process if available.
- If facility wound management process not available:
    - Assess wound and/or dressing daily, and complete wound measurements with dressing changes.
    - Moisturizing cream (facility stock) bid prn for dry skin.
    - Moisture barrier ointment or cream (facility stock) bid as indicated to keep irritants or moisture from skin surface.
    - Treat minor skin tears by cleansing with normal saline or non-cytotoxic wound cleanser. Apply skin sealant to intact periwound skin, let dry. If viable flap is present, approximate edges. Cover with non-adherent dressing and secure with roll gauze, tubular stockinette, or appropriate cover dressing. Change q 3 days and prn.
    - Treat abrasions by cleansing with normal saline or non-cytotoxic wound cleanser. Cover with non-adherent dressing and secure with roll gauze, tubular stockinette, or appropriate cover dressing.
    - Stage 2 or 3 Pressure Injuries (moderate to heavy drainage): cleanse with normal saline or non-cytotoxic wound cleanser. Apply adhesive foam dressing (facility stock); change q 2-3 days and prn. Notify provider next business day.
    - Stage 2 or 3 Pressure Injuries (minimal drainage): Cleanse with normal saline or non-cytotoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with non-adherent dressing. Change q 3 days and prn. Notify provider next business day.
    - May initiate pressure reduction mattress and/or occupational therapy wheelchair positioning eval and treat as clinically indicated for patients with, or at high risk for, skin breakdown (e.g., mobility impairment, prolonged bed rest or fragile skin).
    - Discontinue dressings and other treatments when wound resolved.

Advance Directives

- For change in condition, review POLST and advance directives before calling 911.
- If patient transferred out of facility, send copy of POLST with patient.
- Release body to mortuary at time of an expected death; contraindicated if meets coroner notification.
- Notify provider during business hours of death, next business day if death occurs after-hours.

Localized Allergic Reaction

- Symptoms may include localized skin reaction of itching, redness, urticaria (hives), and/or warmth.
- Management:
    1. Notify provider.
    2. Apply cold compress to specific site PRN.

Generalized Allergic Reaction

- Symptoms may include generalized itching, redness, urticaria (hives), skin warmth, sneezing, voice hoarseness, and/or headache.
- Management:
    1. Notify provider.
    2. Assess for angioedema, difficulty breathing, shock.
    3. Monitor BP, HR, O_2 sats.

Anaphylactic reaction

- Symptoms may include any of the following:
    - Angioedema: swelling of the lips, face, throat or tongue, lump or tightness in throat.
    - Difficulty breathing or inhaling, severe bronchospasm (wheezing).
    - Shock: tachycardia (rapid heart rate), tachypnea (rapid breathing), hypotension (systolic BP < 90).
    - May also include generalized allergic reaction symptoms (noted above).
- If angioedema, difficulty breathing, wheezing, or shock present:
    1. Call 911 and notify provider.
    2. Assess airway, breathing, circulation, and level of consciousness.
    3. Administer epinephrine: EpiPen 0.3 mg (patients >66 pounds) IM x 1; may repeat once after 5-15 minutes after 1st dose if symptoms are still present and EMS has not arrived.
    4. Administer Diphenhydramine (Benadryl) 25 mg po or IM x 1. Contact provider if repeat dosing is needed.
    5. Monitor patient closely until EMS arrives. Follow patient's resuscitation orders per POLST if necessary. Monitor pulse, BP, O_2 sats every 5 minutes.

Additional Facility-Specific Orders or noted changes from MAGIC ACE Version:

Patient Name/Sticker:

Provider Signature: _____ **Date**: _____

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