

SEND TO PHARMACY  
IMMEDIATELY

Please check the box to the left of the appropriate facility:  
 Pitt County Memorial Hospital     Roanoke-Chowan Hospital     Brody School of Medicine at East Carolina University  
 Bertie Memorial Hospital     SurgiCenter Services of Pitt     The Outer Banks Hospital  
 Chowan Hospital     Heritage Hospital

DATE	HOUR	NURSES NOTATIONS	ORDERS:	Health Span: 100144
			<b>NUR: IV or IA POST THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE</b>	
			<b>ADMISSION / TRANSFER / INFORMATION:</b>	
			Admit to: Intensive Care Unit (ICU) Dr. _____	
			Diagnosis: Ischemic Stroke, Thrombolytic Recipient <input type="checkbox"/> Pharrmacological Alteplase : <input type="checkbox"/> IV <input type="checkbox"/> IA <input type="checkbox"/> Mechanical : <input type="checkbox"/> Merci <input type="checkbox"/> EKOS	NIHSS Score: _____
			<b>CODE STATUS: Implement End of Life/ Patient Care Orders (Form # 7025 REQUIRED)</b>	
			<b>Venous ThromboEmbolism Assessment: DVT/ VTE</b>	
			<input type="checkbox"/> Patient AT Risk: <input type="checkbox"/> Prophylaxis included in these admission orders <input type="checkbox"/> Prophylaxis Contraindicated: _____ (List Contraindication) <input type="checkbox"/> Patient NOT at Risk	
			<b>VITAL SIGNS:</b>	
			<input checked="" type="checkbox"/> Monitor Blood Pressure, Heart Rate, Respirations and NIHSS: Every 15 minutes for 2 hours, then every 30 minutes for 6 hours, then every hour for 18 hours	
			<input checked="" type="checkbox"/> Notify Provider for any of the following:	
			<input type="checkbox"/> Standard parameters	<input type="checkbox"/> Custom parameters
			<ul style="list-style-type: none"> <li>• Temperature &gt; 38.1<sup>o</sup>C</li> <li>• Systolic Blood Pressure &gt; 185 or &lt; 100mmHg</li> <li>• Diastolic Blood Pressure &gt; 105 or &lt; 60mmHg</li> <li>• Heart Rate &gt; 120 or &lt; 60 per minute</li> <li>• Respirations &gt; 30 or &lt; 10 per minute</li> <li>• Urine Output &lt; 200 mL every 4 hours</li> <li>• Seizures, Headache, Vomiting</li> </ul>	<ul style="list-style-type: none"> <li>• Temperature &gt; _____<sup>o</sup>C</li> <li>• Systolic Blood Pressure &gt; ____ or &lt; ____ mmHg</li> <li>• Diastolic Blood Pressure &gt; ____ or &lt; ____ mmHg</li> <li>• Heart Rate &gt; _____ or &lt; _____ per minute</li> <li>• Respirations &gt; _____ or &lt; _____ per minute</li> <li>• Urine Output &lt; _____ mL every 4 hours</li> <li>• Seizures, Headache, Vomiting</li> </ul>
			<b>ACTIVITY:</b>	
			<input checked="" type="checkbox"/> Bedrest	
			<b>ALLERGIES: (List Reaction)</b>	<input type="checkbox"/> No Known Drug Allergies (NKDA)

M.D. / \_\_\_\_\_

Physician # / \_\_\_\_\_

Pager # \_\_\_\_\_



207/3390

**PHYSICIAN ORDERS**

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			<b>NUR: IV or IA POST THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE</b>							
			<b>NURSING:</b>							
			<input checked="" type="checkbox"/> Intake and Output every shift <input checked="" type="checkbox"/> Dysphagia Screen <input checked="" type="checkbox"/> Implement the following precautions: <table border="1" style="width:100%; margin-top: 5px;"> <tr> <td style="width:33%;">No ABG</td> <td style="width:33%;">No Arterial or Central Lines</td> <td style="width:33%;">No Heparin</td> </tr> <tr> <td>No IM Injections</td> <td>No NG tube or Foley catheter</td> <td>No Aspirin or Warfarin for 24 hours</td> </tr> </table>		No ABG	No Arterial or Central Lines	No Heparin	No IM Injections	No NG tube or Foley catheter	No Aspirin or Warfarin for 24 hours
No ABG	No Arterial or Central Lines	No Heparin								
No IM Injections	No NG tube or Foley catheter	No Aspirin or Warfarin for 24 hours								
			<input checked="" type="checkbox"/> Oxygen at 2 Liters per minute via nasal cannula (OPTIONAL) <input type="checkbox"/> Elevate head of bed to 30° degrees <input type="checkbox"/> Elevate head of bed to ____ degrees <input type="checkbox"/> May place one pillow under knee if desired <input type="checkbox"/> May bend uninvolved leg <input type="checkbox"/> Head of bed may be raise to 30° degrees <input type="checkbox"/> Puncture Site assessment with Vital Signs <input type="checkbox"/> Neurological checks with Vital Signs <input type="checkbox"/> Distal Pulse / Vascular checks with Vital Signs <input type="checkbox"/> Cardiac Monitor Transport off monitor per nursing assessment guidelines: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> HOLD ordered diet for ____ hours post procedure <input type="checkbox"/>							
			<b>Choose one Mechanical VTE / DVT Prophylaxis</b>							
			<input type="checkbox"/> Sequential Compression Device (SCD) <input type="checkbox"/> Arterio- Venous Impulse Pump (Foot Pump)							
			<b>Mechanical Ventilation:</b>							
			<input type="checkbox"/> See Mechanical Ventilation Order set							
			<b>DIET:</b>							
			<input type="checkbox"/> NPO <input type="checkbox"/> NPO for 12 hours <input type="checkbox"/> NPO for 24 hours							
			<b>IV FLUIDS:</b>							
			<input type="checkbox"/> Saline Lock <input type="checkbox"/> Normal Saline at 75 mL / hour <input type="checkbox"/> _____ at _____ mL / hour							

M.D. / \_\_\_\_\_ Physician # / \_\_\_\_\_ Pager #



**PHYSICIAN ORDERS**

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Please check the box to the left of the appropriate facility:

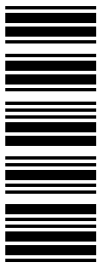
- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Pitt County Memorial Hospital | <input type="checkbox"/> Roanoke-Chowan Hospital      | <input type="checkbox"/> Brody School of Medicine at East Carolina University |
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| <input type="checkbox"/> Chowan Hospital                          | <input type="checkbox"/> Heritage Hospital            |   |

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			<b>NUR: IV or IA POST THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE</b>	
			<b>CONSULTS:</b>	
			<input type="checkbox"/> Occupational Therapy for evaluation and treatment <input type="checkbox"/> Physical Therapy for evaluation and treatment <input type="checkbox"/> Speech Therapy for Speech / Language / Cognitive evaluation and treatment <input type="checkbox"/> Speech Therapy for Swallow Evaluation (Complete Dysphagia Screen) <input type="checkbox"/> NeuroSurgery Consult <input type="checkbox"/> Acute Stroke Nurse to assist with Promoting Best Practice Guidelines <input type="checkbox"/> Acute Stroke Nurse Practitioner to assist with Promoting Best Practice Guidelines	

M.D. / \_\_\_\_\_

Physician # / \_\_\_\_\_

Pager # \_\_\_\_\_



207/ 3390

**PHYSICIAN ORDERS**

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\_\_\_\_\_ M.D. / \_\_\_\_\_ Physician # / \_\_\_\_\_ Pager #



**PHYSICIAN ORDERS**

Patient ID

## NATIONAL INSTITUTES OF HEALTH STROKE SCALE

Tested Item	Title	Responses	SCORES
1A	<b>Level of Consciousness</b>	0 – alert 1 – drowsy 2 – obtunded 3 – coma/unresponsive	_____
1B	<b>Orientation questions (two)</b>	0 -- answers both correctly 1 – answers one correctly 2 – answers neither correctly	_____
1C	<b>Response to commands (two)</b>	0 – performs both tasks correctly 1 – performs one task correctly 2 – performs neither	_____
2	<b>Gaze</b>	0 – normal horizontal movements 1 – partial gaze palsy 2 – complete gaze palsy	_____
3	<b>Visual Fields</b>	0 – no visual field defect 1 – partial hemianopia 2 – complete hemianopia 3 – bilateral hemianopia	_____
4	<b>Facial movement</b>	0 – normal 1 – minor facial weakness 2 – partial facial weakness 3 – complete unilateral palsy	_____
5	<b>Motor functions (arm)</b> a. <b>Left</b> b. <b>Right</b>	0 – no drift 1 – drift before 5 seconds 2 – falls before 10 seconds 3 – no effort against gravity 4 – no movement	L _____ R _____
6	<b>Motor function (leg)</b> a. <b>Left</b> b. <b>Right</b>	0 – no drift 1 – drift before 5 seconds 2 – falls before 5 seconds 3 – no effort against gravity 4 – no movement	L _____ R _____
7	<b>Limb ataxia</b>	0 – no ataxia 1 – ataxia in one limb 2 – ataxia in two limbs	_____
8	<b>Sensory</b>	0 – no sensory loss 1 – mild sensory loss 2 – severe sensory loss	_____
9	<b>Language</b>	0 – normal 1 – mild aphasia 2 – severe aphasia 3 – mute or global aphasia	_____
10	<b>Articulation</b>	0 – normal 1 – mild dysarthria 2 – severe dysarthria	_____
11	<b>Extinction or inattention</b>	0 – absent 1 – mild (loss 1 sensory modality) 2 – severe (loss 2 modalities)	_____
<b>TOTAL SCORE:</b>			_____

**Completed by:**

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



395 / 7047

## Dysphagia Screen

A Dysphagia Screen may be performed on admission or during the hospital stay for any patient suspected of swallowing difficulty.

### Dysphagia Screen: Patient must be:

1) Alert 2) Able to participate 3) Able to sit upright ( 90 degrees preferred ) for 30 minutes.

### If not, keep NPO until criteria met.

### Does the patient have a confirmed diagnosis by a physician or a history of any of the following disorders:

- |                        |                                 |   |
|------------------------|---------------------------------|---|
| 1) Brainstem Stroke    | 5) Myasthenia Gravis            | 8) Moderate to Severe Unilateral Stroke |
| 2) Bilateral Strokes   | 6) Laryngeal Trauma             | 9) Current Aspiration Pneumonia         |
| 3) Parkinson's Disease | 7) Oral and/or Laryngeal Cancer | 10) Recurring Aspiration Pneumonia      |
| 4) Failure to Thrive   |                                 |   |

Yes

No

### Does the patient exhibit any CLINICAL FACTORS associated with Dysphagia:

- |   |                                   |                        |
|---|-----------------------------------|------------------------|
| 1) Moderate to severe slurred speech      | 4) abnormal voice                 | 7) weak or absent gag  |
| 2) Wet or gurgly voice or breath sounds   | 5) inability to manage secretions | 8) cough after swallow |
| 3) Significant facial or lingual weakness | 6) weak or absent cough           | 9) tracheostomy tube   |

Yes

No

### Does the patient or patient's family report difficulty swallowing:

- 1) "food gets stuck" 2) "strangling" or "choking" 3) inability to swallow 4) painful swallowing.

Yes

No

### If all boxes checked NO, administer 10 cc of water from a cup (no straws) and observe.

### Does patient exhibit:

- 1) wet, gurgly voice 2) cough after swallow 3) throat clearing 4) watery eyes 5) runny nose

Yes

No

If ALL boxes are checked No, Contact MD for diet order, including restrictions (ie low sodium, low fat). Recommend appropriate texture based on status of dentition ( pureed diet, mech soft diet, soft to chew diet). Request dietary consult.

If ANY boxes are checked Yes, patient is to remain NPO. Contact MD for order to obtain a Speech Consult for Bedside Swallow Evaluation. Evaluations will be conducted between 0730 and 1600 seven days a week.

**Department of Speech Pathology 847-4448.**

**IF PATIENT EXHIBITS NEURO CHANGES, REPEAT DYSPHAGIA SCREEN.  
RECOMMEND BEDSIDE SWALLOW EVAL IF THERE ARE ANY CONCERNS.**