Physician Orders ADULT: Acute Stroke ICU Plan EKM

Initiate Orders Phase
Care Sets/Protocols/PowerPlans

☑ Initiate Powerplan Phase
  Phase: Acute Stroke ICU Phase, When to Initiate:____________________

☐ Initiate Powerplan Phase
  Phase: Mechanically Ventilated Patients (Vent Bundle) Phase, When to Initiate:____________________

Acute Stroke ICU Phase
Non Categorized
R  Acute Stroke ICU Care Track
R  Stroke Quality Measures
☐ Add To Problem List
  Problem: Stroke
☐ Add To Problem List

Admission/Transfer/Discharge
☐ Patient Status Initial Inpatient
  T;N

Vital Signs
☑ Vital Signs w/Neuro Checks
  Monitor and Record Resp Rate Monitor and Record Blood Pressure Monitor and Record Pulse, q1h(std)
  Comments: Utilize the National Institutes of Health Stroke Scale (NIHSS)

☑ Vital Signs
  Monitor and Record Temp, q4h(std)

Activity
☐ Activity As Tolerated
☐ BR
☐ Bedrest
  Options: w/BRP
☐ Out Of Bed
  Up To Bedside Commode

Food/Nutrition
☑ NPO
  until swallowing screen passed
☐ NPO
  until speech therapy completes evaluation for dysphagia
☐ Regular Adult Diet
☐ Clear Liquid Diet
  Start at: T;N
☐ Full Liquid Diet
  Start at: T;N
☐ Pureed Diet
☐ Mechanical Soft Diet

Patient Care
NOTE: Keep Flat order is contraindicated in head bleeds or confirmed swelling of the brain. Use the Elevate Head of Bed order for these situations.(NOTE)*

☐ Elevate Head Of Bed
  30 degrees
  Comments: For head bleeds or confirmed swelling of the brain.

☐ Keep Flat
  Head of bed flat for 24 hours
  Comments: OK for PT/OT/ST to evaluate and treat as tolerated

☐ Keep Flat
  Head of bed flat for 48 hours
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Comments: OK for PT/OT/ST evaluations up to 10 minutes out of bed.

☐ Keep Flat

Strict head of bed flat for 24 hours

☑ Instruct/Educate

Method: Provide Pamphlet, Topic: Stroke Patient Education Pack, give stroke patient education pack (stroke education with smoking cessation education)

☐ Intake and Output

q4h(std), Strict I & O q4h or more often if needed.

☐ Seizure Precautions

NOTE: If patient is NPO, order Accucheck q6h; if patient has diet order, order Accuchecks AC/HS(NOTE)*

☐ Accucheck Nsg

q6h(std)

☐ Accucheck Nsg

achs

☐ Oxygen Sat Monitoring NSG

q4h(std)

☐ Code Status

Resus Type: DNR-Do Not Resuscitate

☑ Depression Screening

T;N

Nursing Communication

☐ Nursing Communication

T;N, complete Ischemic Stroke NIH Stroke Scale Assessment Form

☑ Nursing Communication

T;N, Ensure that Swallowing Screen is completed

☑ Nursing Communication

T;N, if Alteplase given, hold antithrombotic for 24 hours.

Respiratory Care

☐ Oxygen-Nasal Cannula

Special Instructions: Maintain Oxygen Saturation greater than or equal to 94%

☐ Oxygen-Aerosol Facemask

Special Instructions: Maintain Oxygen Saturation greater than or equal to 94%

NOTE: If a mechanical ventilator is needed please order the Mechanically Ventilated Patient Phase (Vent Bundle Phase) in this Plan.(NOTE)*

Medications

NOTE: Select below to document Antithrombotic Agent contraindication(NOTE)*

☐ Reason Antithrombotics Not Given by End Day 2

NOTE: If not contraindicated, select Antithrombic Agent below:(NOTE)*

+1 Hours aspirin-dipyridamole

1 cap, ER Capsule, PO, bid, Routine

+1 Hours clopidogrel

☐ 75 mg, Tab, PO, QDay, Routine (DEF)*

☐ 75 mg, Tab, NG, QDay, Routine

+1 Hours atorvastatin

☐ 80 mg, Tab, PO, hs, Routine [Less Than 75 year] (DEF)*

☐ 80 mg, Tab, NG, hs, Routine [Less Than 75 year]

☐ 40 mg, Tab, PO, hs, Routine [Greater Than or Equal To 75 year]

☐ 40 mg, Tab, NG, hs, Routine [Greater Than or Equal To 75 year]

+1 Hours pantoprazole

☐ 40 mg, DR Tablet, PO, QDay, Routine (DEF)*

Comments: DO NOT CHEW,CUT, OR CRUSH

☐ 40 mg, Granule, NG, QDay, Routine
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+1 Hours aspirin

81 mg, DR Tablet, PO, QDay, Routine (DEF)*
Comments: If unable to take PO, give aspirin 300 mg rectally

81 mg, Chew tab, NG, QDay, Routine
Comments: Crushed

325 mg, DR Tablet, PO, QDay, Routine
Comments: If unable to take PO, give aspirin 300 mg rectally.

325 mg, Tab, NG, QDay, Routine
Comments: Crushed

300 mg, Supp, PR, QDay, Routine

Neuro Sodium Support Plan(SUB)*

Insulin SENSITIVE Sliding Scale Plan(SUB)*

Insulin STANDARD Sliding Scale Plan(SUB)*

Insulin RESISTANT Sliding Scale Plan(SUB)*

VTE Stroke Prophylaxis Plan(SUB)*

Neuro Antihypertensive Acute PRN Meds Plan(SUB)*

Laboratory

CBC
Routine, T;N, once, Type: Blood

Lipid Profile
Routine, T+1;0400, once, Type: Blood
Comments: fasting

PT/INR
Routine, T;N, once, Type: Blood

PTT
Routine, T;N, once, Type: Blood

Hgb A1C
Routine, T;N, once, Type: Blood

RPR Screen w/Reflex to Titer
Routine, T;N, once, Type: Blood

BMP
Routine, T;N, once, Type: Blood

Magnesium Level
Routine, T;N, once, Type: Blood

AST
Routine, T;N, once, Type: Blood

ALT
Routine, T;N, once, Type: Blood

Homocyst(e)ine
Routine, T;N, once, Type: Blood

CK
Routine, T;N, once, Type: Blood

CRP
Routine, T;N, once, Type: Blood

Urinalysis w/Reflex Microscopic Exam
Routine, T;N, once, Type: Urine, Nurse Collect

Diagnostic Tests

CT Brain/Head WO Cont
T;N, Reason for Exam: CVA (Cerebrovascular Accident), Routine, Stretcher

CT Angio Head W/WO Cont W Imag Post Prc Plan(SUB)*

CT Angio Neck W/WO Cont W Imag Post Pro Plan(SUB)*

MRI Brain & Stem WO Cont
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T:N, Reason for Exam: CVA (Cerebrovascular Accident), Routine, Stretcher

- Consult Radiology Special Procedures
  T:N, Reason for Exam: Other, Enter in Comments, Routine, Stretcher
  Comments: CVA (Cerebrovascular Accident)

- TTE Echo W/Contrast or 3D if needed
  Start at: T:N, Priority: Routine, Other reason: CVA, Transthoracic Echocardiogram

- Transesophageal Echo W/3D if needed
  Start at: T:N, Priority: Routine, Reason: Other, specify, Other reason: CVA

Consults/Notifications/Referrals

- Notify Physician-Once
  Notify: physician, Notify For: room number on arrival to unit

- Notify Physician-Once
  Notify: Cardiologist known to patient, Notify For: if reason admitted cardiology related or if post-discharge follow up or testing indicated.

- Physician Consult
- Consult Endocrinology Group
  Routine, Group: UTMG Endocrinology, Reason for Consult: Hgb A1C greater than or equal to 10

- Notify Physician For Vital Signs Of
  Notify: Physician, BP Systolic > 220 mmHg, BP Diastolic > 120 mmHg, BP Systolic < 120 mmHg, BP Diastolic < 60 mmHg, Celsius Temp > 37.4, Celsius Temp < 36, Heart Rate > 120 bpm, Heart Rate < 50 bpm, Resp Rate > 24 br/min, Resp Rate < 10 br/min, Oxygen Sat

- Notify Physician-Continuing
  Notify: MD, Notify For: immediately for vital signs outside parameters.
- Notify Physician-Continuing
  Notify: MD, Notify For: immediately for evidence of neurological deterioration.

Mechanically Ventilated Patient Phase
Non Categorized

- PT Initial Evaluation and Treatment
- ST Initial Evaluation and Treatment
- ST Subsequent Order
- OT Initial Evaluation and Treatment
- Case Management Consult
- Medical Social Work Consult
- Nursing Communication
  Consult Health South Clinical Coordinator

Patient Care

- Elevate Head Of Bed
  30 degrees or greater if systolic blood pressure is greater than 95 mmHg
- Reposition ETT (Nsg)
  QDay, Rotate tube from one side to the other to reduce the risk of skin breakdown.
- ETT Subglottic Suction
  - Low Continuous, 20mmHg, Applies to ETT with the Hi-Lo suction capability.
  - Low Intermittent, 40mmHg, Applies to ETT with the Hi-Lo suction capability.
  - Low Intermittent, 60mmHg, Applies to ETT with the Hi-Lo suction capability.
  - Low Intermittent, 80mmHg, Applies to ETT with the Hi-Lo suction capability.
  - Low Intermittent, 100mmHg, Applies to ETT with the Hi-Lo suction capability.
- Mouth Care
  Routine, q2h(std)
- Nursing Communication
  Call MD if higher than any of the following maximum doses of medications is required. LORazepam
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6 mg in 3 hours, Fentanyl 500 mcg/hr, propofol 100 mcg/kg/min, midazolam 7mg/hr

☐ Nursing Communication
If SAS goal not met in 6 hours, call MD for further orders

☐ Nursing Communication
If receiving haloperidol, patient must be on cardiac monitor - call MD for QTc prolongation greater than or equal to 500 msecs and HOLD haloperidol

☐ Nursing Communication
Once SAS goal is met initially, reassess and document SAS score q2hrs

☐ Nursing Communication
If the patient is on sedation medication other than propofol, begin turning off the sedation medications at 8am for the sedation vacation process

☐ Nursing Communication
Notify Respiratory for Weaning Assessment at 8am if a Vacation Sedation is initiated,

Respiratory Care

☐ Mechanical Ventilation

☐ Reposition ETT (Nsg)
QDay, Rotate tube from one side to the other to reduce the risk of skin breakdown.

Medications

☐ +1 Hours docusate
100 mg, Liq, NG, bid, Routine
Comments: HOLD for diarrhea

☐ +1 Hours famotidine
20 mg, Tab, NG, bid, Routine
Comments: reduce to 20 mg daily if creatinine clearance is less than 50 mL/min

☐ +1 Hours famotidine
20 mg, Injection, IV Push, bid, Routine
Comments: reduce to 20 mg daily if creatinine clearance is less than 50 mL/min

☐ +1 Hours pantoprazole
40 mg, Granule, NG, QDay, Routine

☐ +1 Hours pantoprazole
40 mg, Injection, IV Push, QDay, Routine

☐ +1 Hours Chlorhexidine For Mouthcare 0.12% Liq
15 mL, Liq, Mucous Membrane, bid, Routine
Comments: For mouthcare at 0800 and 2000.

☐ VTE MEDICAL Prophylaxis Plan(SUB)*

☐ VTE SURGICAL Prophylaxis Plan(SUB)*

☐ Sequential Compression Device Apply
T:N, Apply to Lower Extremities

Sedation
Refer to Patient Care Section/Nursing communication orders for medication monitoring parameters.(NOTE)* Choose Sedation Goal per Riker Sedation Agitation Scale (SAS) Goal of 3-4 recommended (NOTE)*

☐ Sedation Goal per Riker Scale
☐ Goal: 3 (Sedated) (DEF)*
☐ Goal: 4 (Calm/Cooperative)

☐ Propofol Orders Plan(SUB)*

☐ +1 Hours LORazepam
1 mg, Injection, IV Push, q30min, PRN Other, specify in Comment, Routine, Indication: NOT for Violent Restraint
Comments: To maintain SAS goal (Maximum of 6 mg in a 3 hr period). If patient is over-sedated, hold dose until SAS goal achieved. Call MD if patient requires more than 20 mg/day.

☐ +1 Hours midazolam
1 mg, Injection, IV Push, q1h, PRN Other, specify in Comment, Routine, Indication: NOT for Violent Restraint
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Comments: To maintain SAS goal. If patient is over sedated, hold dose until SAS goal achieved. Call MD if patient requires more than 20 mg/day.

+1 Hours midazolam 1mg/mL/NS 50 mL PreMix
50 mg / 50 mL, IV, Routine, titrate
Comments: Initiate at 1 mg/hr. Titrate by 0.5mg/hr every 15 minutes until SAS goal achieved. Maximum dose 7 mg/hr

+1 Hours dexmedetomidine infusion (ICU Sedation) (IVS)*
Sodium Chloride 0.9%
100 mL, IV, (for 72 hr ), Titrate
Comments: Concentration: 4 mcg/mL Initiate infusion at 0.2 mcg/kg/hr. Titrate by 0.1 mcg/kg/hr every 30 minutes to reach goal sedation of Riker 3-4. DO NOT BOLUS dose at any time. DO NOT TITRATE MORE FREQUENTLY THAN EVERY 30 MIN.
dexmedetomidine (additive)
400 mcg

Pain Management
Choose one of the orders below, morPHINE is not recommended if creatinine clearance is less than 50 mL/min, in liver failure or SBP less than 90mmhg or MAP less than 65 mmhg.(NOTE)*

+1 Hours morphine
2 mg, Injection, IV Push, q1h, PRN Pain, Moderate (4-7), Routine

+1 Hours HYDROMorphone
0.5 mg, Injection, IV Push, q1h, PRN Pain, Moderate (4-7), Routine

+1 Hours morphine
4 mg, Injection, IV Push, q1h, PRN Pain, Severe (8-10), Routine

+1 Hours HYDROMorphone
1 mg, Injection, IV Push, q1h, PRN Pain, Severe (8-10)

+1 Hours fentaNYL 10 mcg/mL in NS infusion
2,500 mcg / 250 mL, IV, Routine, Titrate
Comments: Concentration 10 mcg/mL Initial Rate: 50 mcg/hr; Titration Parameters: 50 mcg/hr every 10 min to SAS goal per MD orders. Max Rate: 500 mcg/hr

Refractory Agitation
Place order below for agitation that persists despite adequate sedation & analgesia. Refer to Patient Care Section/Nursing communication orders for medication monitoring parameters.(NOTE)*

+1 Hours haloperidol
2 mg, Injection, IV Push, q1h, PRN Agitation, Routine, Indication: NOT for Violent Restraint
Comments: Cardiac monitor required. *If Qtc greater than 500 msec, hold haloperidol. *If SAS not met in 6 hrs, call MD. Call MD is patient requires more than 20 mg/day.

Sedation Vacation Daily
✔ Sedation Vacation qam, see Order Comment:
Comments: For patients receiving continuous infusions, lighten/discontinue sedation and pain medications at 0800 daily (or more often as indicated by MD/required by nsg unit) until the patient is awake, can follow commands, or until they become uncomfortable or agitated. Resume sedation infusion at 1/2 the previous rate and re-titr rate to SAS goal. If SAS goal still achieved without active therapy, do not restart sedation. If patient becomes agitated, resume sedation infusion at 1/2 the previous rate & re-titr to SAS goal (document on the nursing flow sheet)

✔ Ventilator Weaning Trial Medical by RT

Consults/Notifications/Referrals
✔ Notify Physician-Continuing
Notify: MD, Notify For: QTc prolongation on cardiac monitor greater than or equal to 500msecs and HOLD haloperidol
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<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Physician’s Signature</th>
<th>MD Number</th>
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*Report Legend:*
- **DEF** - This order sentence is the default for the selected order
- **GOAL** - This component is a goal
- **IND** - This component is an indicator
- **INT** - This component is an intervention
- **IVS** - This component is an IV Set
- **NOTE** - This component is a note
- **Rx** - This component is a prescription
- **SUB** - This component is a sub phase, see separate sheet
- **R** - Required order