Physician Orders ADULT: Neuro Intracerebral Hemorrhage Plan

Initiate Orders Phase
Admission/Transfer/Discharge

- [ ] Patient Status Initial Inpatient
  - [ ] T;N, Admitting Physician: ________________________________
  - Reason for Visit: __________________________________________
  - Bed Type: Critical Care Specific Unit: Neuro CCU (DEF)*
  - Care Team: ____________________________________________ Anticipated LOS: 2 midnights or more

- [ ] T;N, Admitting Physician: ________________________________
  - Reason for Visit: __________________________________________
  - Bed Type: Med-Surg Specific Unit: 9A Tower
  - Care Team: ____________________________________________ Anticipated LOS: 2 midnights or more

Care Sets/Protocols/PowerPlans

- [ ] Initiate Powerplan Phase
  - Phase: Neuro Intracerebral Hemorrhage Phase
  - When to Initiate: ________________________________

- [ ] Initiate Powerplan Phase
  - Phase: Mechanically Ventilated Patients (Vent Bundle) Phase
  - When to Initiate: ________________________________

Neuro Intracerebral Hemorrhage Phase
Admission/Transfer/Discharge

- [ ] Notify Physician-Once
  - Notify For: of room number on arrival to unit

Vital Signs

- [ ] Vital Signs
  - Monitor and Record Temp, q4h(std)

- [ ] Vital Signs w/Neuro Checks
  - [ ] Monitor and Record Resp Rate Monitor and Record Blood Pressure Monitor and Record Pulse, q1h(std), O2 sat (DEF)*
    - Comments: Utilize the National Institutes of Health Stroke Scale (NIHSS)
  - [ ] Monitor and Record Resp Rate Monitor and Record Blood Pressure Monitor and Record Pulse, q2h(std), O2 sat
    - Comments: Utilize the National Institutes of Health Stroke Scale (NIHSS)

- [ ] Central Venous Pressure Monitoring
  - q6h(std), Monitor and record

Activity

- [ ] Bedrest
- [ ] Bedrest
  - BRP
- [ ] Out Of Bed
  - Up As Tolerated
- [ ] Out Of Bed
  - Up To Chair, tid
- [ ] Ambulate
  - Up To Ambulate in Hall, Daily

Food/Nutrition

- [ ] NPO
  - until swallow screen passed (DEF)*
  - Instructions: NPO except for medications
- [ ] Clear Liquid Diet
  - Start at: T;N, Adult (>18 years)
- [ ] Full Liquid Diet
  - Start at: T;N, Adult (>18 years)
- [ ] Regular Adult Diet
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☐ Mechanical Soft Diet
   Adult (>18 years)
☐ Pureed Diet
   Adult (>18 years)
☐ Consistent Carbohydrate Diet
   T;N, Caloric Level: 1800 Calorie, Insulin: [] No Insulin [] Short Acting
   [ ] Intermediate [ ] Long Acting [ ] Short and Intermediate [ ] Short and Long;
   Renal Patient: [ ] No [ ] Yes, on dialysis [ ] Yes, not on dialysis
☐ American Heart Association Diet
   Adult (>18 years)

Patient Care
☐ VTE MEDICAL Prophylaxis Plan(SUB)*
☐ Code Status
☐ Weight
   Routine, QODay, Weigh patient every other day
☐ Elevate Head Of Bed
   30 degrees at all times
☐ Nursing Communication
   Ensure Swallow Screen and Stroke Education complete and charted in the electronic medical record
☐ O2 Sat Continuous Monitoring NSG
   Routine
☐ Seizure Precautions
   Routine
☐ Increased ICP Precautions
   Routine
☐ Intake and Output
   Routine, q4h(std)
☐ Intake and Output
   Routine, q-shift
☐ Indwelling Urinary Catheter Insert-Follow Removal Protocol
to bedside gravity drain
☐ Indwelling Urinary Catheter Care
   q-shift
☐ Continue Foley Per Protocol
   Reason: Vent & Paralyzed, Condom Cath No Option
☐ INT Insert/Site Care
☐ Whole Blood Glucose Nsg
   q4h(std), If tolerating PO or intermittent feeds, may decrease frequency of Whole Blood Glucose Nsg
toachs.
☐ Restrict Fluids
   Routine, Restrict Amount to: ____________
☐ Advance Diet As Tolerated
☐ Nasogastric Tube Insert
   Routine
☐ Nasogastric Tube
   for medication administration and nutrition.
☐ Oral Gastric Tube Insert
☐ Oral Gastric Tube Care
   for medication administration and nutrition.
☐ Instruct/Educate
   Instruct: Patient and Family, Topic: Stroke Patient Education
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- Ventriculostomy Setup To Bedside
  - Routine
- Neuro Arteriogram Post Procedure Plan(SUB)*
- Neuro Ventriculostomy Plan(SUB)*
- Depression Screening
  - T;N

Respiratory Care
- Nasal Cannula
  - 2 L/min, Special Instructions: Titrated to keep O2 saturation greater than or equal to 94%
- Nasal Cannula
  - Special Instructions: per Oxygen Administration Policy, titrate to keep O2 saturation greater than or equal to 94%
- Aerosol Facemask
  - 40 %, Special Instructions: Titrated to keep O2 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)*

Continuous Infusion
- Sodium Chloride 0.9%
  - 1,000 mL, IV, Routine, 75 mL/hr
- Lactated ringers
  - 1,000 mL, IV, Routine, 75 mL/hr

Medications
- Neuro Antihypertensive Acute PRN Meds Plan(SUB)*
- Neuro Sodium Support Plan(SUB)*
- Insulin SENSITIVE Sliding Scale Plan(SUB)*
- Insulin STANDARD Sliding Scale Plan(SUB)*
- Insulin RESISTANT Sliding Scale Plan(SUB)*
  - NOTE: If needed for the care of this patient, place a separate order for the Intraventricular Alteplase/intracerebral hemorrhage Protocol.(NOTE)*
- Prothrombin Complex Concentrate (Kcentra) for Warfarin-Associated Major Bleeding Plan(SUB)*
- +1 Hours pantoprazole
  - 40 mg, DR Tablet, PO, QDay, Routine (DEF)*
    - Comments: DO NOT CHEW,CUT, OR CRUSH
  - 40 mg, Injection, IV Push, QDay, Routine
  - 40 mg, Granule, NG, QDay, Routine
    - Comments: DO NOT CHEW,CUT, OR CRUSH
- +1 Hours ondansetron
  - 4 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting
- +1 Hours acetaminophen
  - 650 mg, Tab, PO, q6h, PRN Mild Pain or Fever
    - Comments: PRN mild pain or fever greater than 38 degrees C
- +1 Hours acetaminophen
  - 650 mg, Supp, PR, q6h, PRN Mild Pain or Fever
    - Comments: if unable to tolerate PO, PRN mild pain or fever greater than 38 degrees C
- +1 Hours acetaminophen-oxyCODONE 325 mg-5 mg oral tablet
  - 1 tab, Tab, PO, q4h, PRN Pain, Moderate (4-7)
- +1 Hours morphine
  - 2 mg, Injection, IV Push, q4h, PRN Pain, Severe (7-10)

Laboratory
  - NOTE: If no previous CBC, PT, PTT documented, order CBC, PT, PTT, "on arrival" orders below.(NOTE)*
  - CBC
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- **Routine, T;N, once, Type: Blood**
  - Comments: On arrival to unit.

- **CMP**
  - Routine, T;N, once, Type: Blood
  - Comments: On arrival to unit.

- **Magnesium Level**
  - Routine, T;N, once, Type: Blood
  - Comments: On arrival to unit.

- **Phosphorus Level**
  - Routine, T;N, once, Type: Blood
  - Comments: On arrival to unit.

- **PT**
  - Routine, T;N, once, Type: Blood
  - Comments: On arrival to unit.

- **PTT**
  - Routine, T;N, once, Type: Blood
  - Comments: On arrival to unit.

- **Troponin-I**
  - Time Study, T;N, q8h x 3 occurrence, Type: Blood
  - Comments: If first occurrence in ED, will only need two specimens.

- **Phenytoin Level**
  - Routine, T+1;0200, once, Type: Blood

- **CBC**
  - Routine, T+1;0200, q24h x 3 day, Type: Blood

- **BMP**
  - Routine, T+1;0200, q24h x 3 day, Type: Blood

- **Magnesium Level**
  - Routine, T+1;0200, q24h x 3 day, Type: Blood

- **Phosphorus Level**
  - Routine, T+1;0200, q24h x 3 day, Type: Blood

**Diagnostic Tests**

- **EKG**
  - Start at: T;N, Priority: Routine, Reason: Other, specify, Intracerebral hemorrhage

- **Chest 1 View**
  - T+1;0800, Reason for Exam: Other, Enter in Comments, Routine, Portable
  - Comments: Reason for Exam: Intracerebral hemorrhage

- **CT Brain/Head WO Cont**
  - T+1;0800, Reason for Exam: Intracranial Hemorrhage, Routine, Stretcher

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

**Consults/Notifications/Referrals**

- **Notify Physician For Vital Signs Of**
  - Notify: Physician, Celsius Temp > 38.4, Celsius Temp < 35, Heart Rate > 120 bpm, Heart Rate < 50 bpm, Resp Rate > 24 br/min, Resp Rate < 10 br/min, Oxygen Sat < 90% despite O2 treatment

- **Notify Resident-Continuing**
  - Notify: Neurology, Notify For: any change in neuro status or questions

- **Physician Consult**
  - Reason for Consult: for intensive care management and/or ventilator management

- **Physician Consult**
  - Reason for Consult: for intensive care management and/or ventilator management

- **Physician Group Consult**
  - Group: UT Neuro ICU, Reason for Consult: for intensive care management and/or ventilator management

- **Occupational Therapy Initial Eval and Tx**
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- **Routine**
  - Physical Therapy Initial Eval and Tx
  - Speech Therapy Initial Eval and Tx
    - for: BSE (Bedside Swallow Eval)
  - Case Management Consult
    - Routine, Reason: Discharge Planning
  - Medical Social Work Consult
    - Routine, Reason: Assistance at Discharge

**Mechanically Ventilated Patients Phase**

**Non Categorized**

- Mechanically Ventilated Pt (Vent Bundle) Care Track
  - T/N

**Patient Care**

- **Routine**
  - 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. (DEF)*
    - 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.
    - Low Intermittent, 120mmHg, 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 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
  - famotidine
    - 20 mg, Tab, NG, bid, Routine
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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
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
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4 mg, Injection, IV Push, q1h, PRN Pain, Severe (8-10), Routine
- **+1 Hours** HYDROmorphine
  - 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 haldoperidol. *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-titrated 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-titrated 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

Date | Time | Physician’s Signature | MD Number
---|---|---|---

*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