2700

PROVIDENCE Health & Services

PSVMC – Providence St. Vincent Medical Center
PPMC – Providence Portland Medical Center
PMH – Providence Milwaukie Hospital

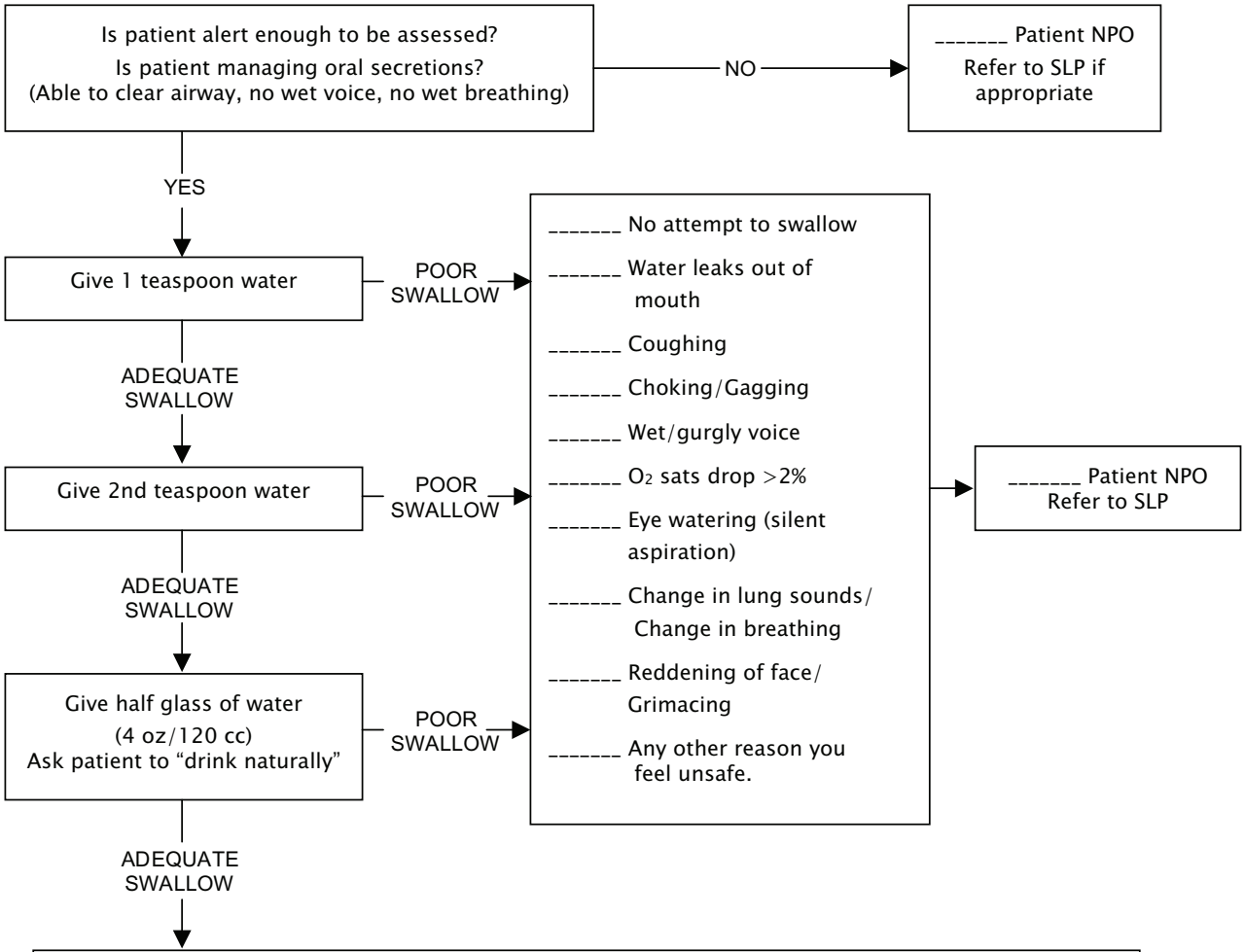
BEDSIDE SWALLOW SCREEN

PATIENT IMPRINT

Baseline O_2 sat:_____ Monitor O_2 sat throughout screen.

Please initial the line to indicate patient's endpoint and write brief summary in Progress Notes or ED Record. When finished, place this form in the "Nursing Flow Sheet and Vitals" tab of patient chart.

Assist the patient with oral care prior to performing the swallow screen.
If diet order and/or referral to Speech-Language Pathology (SLP) is needed, please request MD to order.



_____ Order "Mechanical Soft and Thin Liquid" diet for patients with adequate dentition.
_____ Order "Puree and Thin Liquid" diet for patients with poor dentition.
At first meal check for pocketing, difficulty chewing, and fatigue. Refer to SLP if difficulties are noted. If no problems, advance diet as tolerated.

RN / MD Name: _____ Date: _____ Time: _____

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Source: Providence St. Vincent Medical Center, Portland, OR.

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PHYSICIAN'S ORDER RECORD

PPMC - Providence Portland Medical Center
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PATIENT IMPRINT

Emergency Department
Stroke/TIA/Intracranial Hemorrhage Protocol and Order Set

Note: bulleted orders are implemented unless crossed out. Orders preceded by a box (☐) receive a (✓) to initiate and blanks indicate additional information is needed.

☐ Patient MAY BE a candidate for acute stroke intervention:
Onset less than 8 hours

Time RN Goal

☑ _____ _____ 15 min Page Acute Stroke Team 503-494-9000

Times: Call back_____ at bedside_____

☑ _____ _____ 20 min "Brain Attack/Acute Stroke Protocol"
unenhanced CT head with CTA
head and neck

☐ Patient is NOT candidate for acute stroke intervention:

Reason NOT candidate:
- ☐ Onset greater than 8 hours
- ☐ Symptoms too mild
- ☐ Symptoms improving rapidly
- ☐ Hemorrhage on CT or history of intracranial hemorrhage
- ☐ Other: _____

☑ _____ _____ Stat unenhanced CT head
Time RN

	Time	RN	Goal	
☑	_____	_____		Onset Symptoms/last time known normal
☑	_____	_____	0	Arrival in ED
☑	_____	_____	10 min	ED physician at bedside
☑	_____	_____		Vital signs every 15 minutes if treatment candidate; otherwise ED standard
☑	_____	_____		O2 by nasal cannula to maintain O2 saturation greater than 92%
☑	_____	_____		Insert 2 IV lines (18guage preferred if patient is treatment candidate)
☑	_____	_____		Stat Labs: CBC, PT/INR/aPTT, Nutrition Panel Complete, troponin
☑	_____	_____		NIH Stroke Scale on admission and with any neurological change
☑	_____	_____		Bedside Blood Glucose (CBG x 1) if not available from EMS
☑	_____	_____		IV – Normal Saline @_____ ml/hour
☑	_____	_____		Stat ECG (Do not delay CT to do ECG)
☑	_____	_____		Bedside Swallow Screen – document prior to oral intake including medications. ☐ check here if clearly unsafe to swa llow; if checked, ke ep NPO until cleared
☑	_____	_____		Acetaminophen 650mg PO or per rectum every 4 hours as needed for temperature 37.5C or greater
☐	_____	_____		ASA 325mg PO or per rectum if head CT negative for bleed and not treating with tPA
☐	_____	_____		Place Foley only if admitting to ICU. Must wait at least 30 min after tPA infusion complete.

Hypertension Management Guidelines on back of form

tPA dosing calculations

☐ Patient is candidate for IV tPA (Alteplase). See inclusion/exclusion list on back.
Goal: tPA to start within 60 minutes from arrival

- Blood Pressure must be controlled less than 185/110 prior to tPA start.
- IV tPA (Alteplase) dosing: 0.9mg/kg with maximum dose 90mg.
  0.9mg X _____ (weight in kg) = _____ mg total dose (Concentration: 1mg = 1ml)
- Remove from vial any quantity of drug in excess of total dose (prevents overdosing)
  (100mg - _____ mg total dose = _____ mg to discard)
- IV bolus = 10% of total dose (_____mg) Time given: _____
- Infusion dose = 90% of total dose (_____mg)
  via infusion pump over one hour Time started: _____

Physician Signature: _____Date/Time:_____

RN Signature: _____Date/Time: _____

RN Signature: _____Date/Time: _____

Emergency Department
Stroke/TIA/Intracranial Hemorrhage Protocol and Order Set

INTRAVENOUS tPA FOR ACUTE ST ROKE: ELIGIBILITY CHECKLIST

Inclusion Criteria (All YES boxes must be checked prior to treatment):

YES

- ❑ Clinical diagnosis of ischemic stroke causing a measurable neurological deficit.
- ❑ Time of symptom onset well established to be less than 180 minutes before treatment starts.

Exclusion Criteria (All NO boxes must be checked before treatment):

NO

- ❑ Evidence of intracranial hemorrhage on noncontrast head CT per radiologist or neurologist.
- ❑ High clinical suspicion of subarachnoid hemorrhage even with normal CT.
- ❑ Uncontrolled hypertension: At the time of treatment, systolic pressure r>185mm Hg or diastolic pressure remains >110mm Hg on repeated measurements and aggressive treatment.
- ❑ Seizure at stroke onset.
- ❑ Active internal bleeding
- ❑ Current bleeding diathesis, including but not limited to:
  - Platelet count less than 100,000/millimeter cubed.
  - Recent use of anticoagulant (e.g. Warfarin sodium) and INR greater than 1.7 or Protime greater than 15 seconds.
  - Administration of heparin within 48 hours and an elevated a PTT.
- ❑ Within 3 month of intracranial surgery, serious head trauma, or previous stroke.
- ❑ History of intracranial hemorrhage, AVM, aneurysm, or neoplasm.
- ❑ Recent arterial puncture at noncompressible site.
- ❑ Pregnancy.

Relative Contraindications/Precautions

Only minor or rapidly improving stroke symptoms.
Lumbar puncture within 48 hours.
Major surgery of serious trauma in previous 14 days.
Internal bleeding (GI/GU) within last 21 days.
MI within past 3 months.
Post-MI pericarditis.
CBG or serum glucose less than 50mg/dL or greater than 400mg/dL.

Hypertension Management Guidelines : (Written orders needed)

Ischemic Stroke Non tPA/intervention patient Goal: SBP less than 220 and DBP less than 120 tPA treatment candidate Goal: Less than 185/110	Intracranial Hemorrhage Goal: SBP less than 160 and DBP less than 90; or MAP 110mmHg
• Labetolol 10 to 20mg IV over 1 to 2 minutes; may repeat x 1 • Nicardipine infusion (Cardene) 5mg/hour, titrate up by 2.5mg/hour at 5 to 15 minute intervals, maximum dose 15mg/hour ; when goal attained, reduce to 3mg/hour • Nitro paste 1 to 2 inches	• Labetolol 5 to 20mg IV over 1 to 2 minutes every 15 minutes. • Nicardipine infusion (Cardene) 5mg/hour, titrate up by 2.5mg/hour at 5 to 15 minute intervals, maximum dose 15mg/hour; when goal attained, reduce to 3mg/hour. • Hydralazine 5 to 20mg IVP every 30 minutes.

Source: Providence St. Vincent Medical Center, Portland, OR.

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NIH STROKE SCALE

PSVMC - Providence St. Vincent Medical Center
PMH - Providence Milwaukie Hospital
PPMC - Providence Portland Medical Center
PMMC - Providence Medford Medical Center

PATIENT IMPRINT

Category	Score/Description		Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials
1a. Level of Consciousness (Alert, drowsy, etc.)	0 = Alert 1 = Drowsy 2 = Stuporous 3 = Coma						
1b. LOC Questions (Month, age)	0 = Answers both correctly 1 = Answers one correctly 2 = Incorrect						
1c. LOC Commands (Open/close eyes, make fist/let go)	0 = Obeys both correctly 1 = Obeys one correctly 2 = Incorrect						
2. Best Gaze (Eyes open - patient follows examiner's finger or face)	0 = Normal 1 = Partial gaze palsy 2 = Forced deviation						
3. Visual Fields (Introduce visual stimulus/threat to pt's visual field quadrants)	0 = No visual loss 1 = Partial Hemianopia 2 = Complete Hemianopia 3 = Bilateral Hemianopia (Blind)						
4. Facial Paresis (Show teeth, raise eyebrows and squeeze eyes shut)	0 = Normal 1 = Minor 2 = Partial 3 = Complete						
5a. Motor Arm - Left **5b. Motor Arm - Right** (Elevate arm to 90º if patient is sitting, 45º if supine)	0 = No drift 1 = Drift 2 = Can't resist gravity 3 = No effort against gravity 4 = No movement X = Untestable (Joint fusion or limb amp)	Left					
		Right					
6a. Motor Leg - Left **6b. Motor Leg - Right** (Elevate leg 30º with patient supine)	0 = No drift 1 = Drift 2 = Can't resist gravity 3 = No effort against gravity 4 = No movement X = Untestable (Joint fusion or limb amp)	Left					
		Right					
7. Limb Ataxia (Finger-nose, heel down shin)	0 = No ataxia 1 = Present in one limb 2 = Present in two limbs						
8. Sensory (Pin prick to face, arm, trunk, and leg - compare side to side)	0 = Normal 1 = Partial loss 2 = Severe loss						
9. Best Language (Name item, describe a picture and read sentences)	0 = No aphasia 1 = Mild to moderate aphasia 2 = Severe aphasia 3 = Mute						
10. Dysarthria (Evaluate speech clarity by patient repeating listed words)	0 = Normal articulation 1 = Mild to moderate slurring of words 2 = Near to unintelligable or worse X = Intubated or other physical barrier						
11. Extinction and Inattention (Use information from prior testing to identify neglect or double simultaneous stimuli testing)	0 = No neglect 1 = Partial neglect 2 = Complete neglect						
SEDATING MEDICATIONS AFFECTING SCALE? YES / NO							
		TOTAL SCORE					

INITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

159337 2/08

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SEDATING MEDICATIONS AFFECTING SCALE? YES / NO							
TOTAL SCORE							

INITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

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