STROKE NON-THROMBOLYTIC
Stroke Orders- Ischemic, Non-Thrombolytic

VTE PROPHYLAXIS ORDERS
A VTE Risk Assessment and appropriate treatment or a contraindication to treatment is required for all patients.
Patient has the following VTE Risk:
☐ Low VTE Risk (No prophylaxis needed)
☐ Moderate VTE Risk (Please Order EITHER mechanical (SCD) or pharmacological prophylaxis)
☐ High VTE Risk (Please Order BOTH mechanical (SCD) or pharmacological prophylaxis)

Contraindications
Reason for withholding Mechanical VTE prophylaxis (check one)

☐Hypervolemia
☐Edema of leg
☐Surgical procedure on lower extremity
☐Comfort measures
☐Amputee-limb
☐Deep vein thrombosis of lower extremity
☐Suspected deep vein thrombosis
☐Congestive/Chronic heart failure
☐Palliative care
☐ Injury of lower extremity
☐Dermatitis
☐Peripheral ischemia
☐Deformity of leg
☐Treatment not tolerated
☐Vascular insufficiency of limb
☐Sensory neuropathy
☐Refusal of treatment by patient
☐At risk for falls
☐Skin graft disorder
☐Peripheral vascular disease
☐History of occlusive arterial disease of lower extremity

Reason for withholding Pharmacologic VTE prophylaxis (check one)

☐Blood coagulation disorders
☐Bleeding or at risk for bleeding
☐Renal impairment
☐Anticoagulation not tolerated
☐Palliative care (for end of life)
☐Comfort measures
☐Anticoagulant allergy
☐Platelet count below ref
☐At risk for falls
☐Hemorrhagic cerebral infarction
☐Medications refused

☑ Leg compression device to be placed within 4 hours

For Medical patient, dose should be given at 2100 daily. **Evidence
☐ Enoxaparin (Lovenox) 40 mg SubQ daily. Start today at 21:00.
Pharmacy to adjust per renal dosing protocol. May use baseline PLTS if today's PLTS not yet available.

DIAGNOSIS: Ischemic Stroke without thrombolytics

ADMIT – Select Only One
REMINDER: All stroke patients should go to Medical Telemetry or Critical Care regardless of Admit status
☐ Admit as Inpatient. Preferred unit: Medical Telemetry
Reason to admit: _____
(The physician must document the reason for inpatient).
☐ Admit as Inpatient. Preferred unit: ICU
Reason to admit: _____
(The physician must document the reason for inpatient).
☐ Place in Observation Status. Reason to admit/place: _____
(The physician must document the reason for observation (INo).

CODE STATUS
REMINDER: For DNAR status complete separate DNAR Physician Order Set

SKIN TREATMENT AND PREVENTION
☑ Initiate designated skin set: If Braden score of 18 or less initiate Skin Treatment and Prevention short set. For any other skin issues initiate designated skin order set(s).

NURSING
REMINDER: For patients with a contraindication to anticoagulant therapy and not ambulating independently, use mechanical prophylaxis with compression device Evidence
☑ Initiate full NIH Stroke Scale on admission, and Q Shift
☑ Initiate abbreviated NIH Stroke Scale Q 2 hours x 24 hours
☑ Orthostatic blood pressure prior to first time getting out of bed
☑ Notify Neurologist (or if no neurologist then attending) if:
- •change in neuro status,
- •change in level of consciousness,
- •change in pupil size/reactivity,
- •worsening headache,
- •unexplained vomiting,
- •increased agitation

☑ Notify MD of abnormal vital signs
- •if respiratory rate < 8/min or > 24/min
- •if oxygen saturation is < 92%

☑ RN bedside swallow screen on admission prior to any Po intake Evidence
☐ Blood glucose monitoring (BGM)-on admission one time only. If > 150 mg/dL, notify MD to initiate SubQ Insulin SS
☐ Blood glucose monitoring (BGM)-Q 6 hours while NPO
☐ Blood glucose monitoring (BGM)-AC and HS; Recommended Schedule: 0745, 1100, 1700, 2100
☐ Apply antiembolism stockings
☐ Insert post pyloric tube
☐ Insert nasogastric/orogastric tube
☐ Insert indwelling urinary catheter; Reason: Neurogenic bladder
☐ Incentive spirometry Q 2 hours while awake
☐ Aspiration precautions
☑ Apply telemetry monitor
☐ May leave floor without telemetry monitor

ACTIVITY
REMINDER: If there are no restrictions nursing will ambulate the patient at least four times a day per policy PC-112
☑ Head of bed (HOB) at 90 degrees while eating when patient no longer NPO
☑ Elevate head of bed at 30 degrees and keep head midline

RESPIRATORY
☑ Apply oxygen (O2) with defined parameters to maintain oxygen saturation on > 92%
☑ Continuous pulse oximetry

NUTRITION
REMINDER: Patients with ischemic stroke should undergo a swallowing study before taking any foods, fluids, or medications by mouth Evidence
☑ NPO until swallow screen or swallow eval
☐ Cardiac 2 gram sodium diet
☐ Diabetic 1800 Calorie Controlled Diet
☐ Diabetic 2200 Calorie Controlled Diet

IV FLUIDS
☐ Sodium Chloride 0.9% IV to run at 100 mL/Hr Evidence
☐ Saline lock IV if tolerating Po fluids, Temp < 100.4º F, HCT > 30, and PCA not required. Saline Flush 2 mL IV Push Q 8 Hrs and after each IV medication dose. RN to contact Pharmacy to DC IV Fluid order(s) when IV Fluid is converted to saline lock.

MEDICATIONS

Analgesic/Antipyretic medications: Mild Pain/Fever Evidence

☐ Acetaminophen (Tylenol) 650 mg Po Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC. *Total Acetaminophen not to exceed 4,000 mg/24 Hrs*.

☐ Acetaminophen (Tylenol) liquid 650 mg NG Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC. If patient is unable to take Po acetaminophen (if ordered) and has an NG tube. *Total Acetaminophen not to exceed 4,000 mg/24 Hrs*.

☐ Acetaminophen (Tylenol) Supp 650 mg PR Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC. If patient is unable to take Po/NG acetaminophen (if ordered). *Total Acetaminophen not to exceed 4,000 mg/24 Hrs* .

Anticoagulant medications: LMWHs/UFH/Vitamin K antagonists Evidence

REMINDER: For patients with cerebrovascular disease (e.g., history of TIA or stroke) associated with nonrheumatic atrial fibrillation, atrial flutter, or prosthetic heart valves, administer a vitamin K antagonist. Evidence

REMINDER: For patients with noncardioembolic TIA or ischemic stroke who have no other indications for anticoagulation, do not use warfarin. Evidence

REMINDER: Use the following options for the treatment of Atrial Fibrillation to reduce the risk of recurrent stroke if there are no contraindications to anticoagulation.

☐ Anticoagulation contraindicated:

Reasons to withhold Anticoagulation

☐ History of Ablation for A fib or A flutter	☐Rule out bleed	☐ Bleeding risk
	☐Intolerance in past	☐ Bleeding disorder
☐ Peptic ulcer disease	☐ Intracranial surgery/biopsy	☐ Other: _____
☐ Allergy to or complication related to antithrombotic	☐Planned surgery	
	☐ Hemorrhage	

☐ Enoxaparin (Lovenox) 1 mg/Kg = _____mg SubQ Q 12 Hrs. Pharmacy to adjust per renal dosing protocol. Indication: AFib/Aflutter/or history of

☐ Heparin drip per pharmacy protocol. No bolus. Goal APTT = 55-75 secs Indication: AFib/Aflutter/or history of

☐ Warfarin (Coumadin) per pharmacy protocol. Goal INR= 2-3 Indication: AFib/Aflutter/or history of

Anticoagulant medications: Platelet Inhibitors/Anti-thrombotics ***Physician to select ONE dose only***
Evidence

REMINDER - Aspirin should be administered by end of hospital day 2 and prescribed upon discharge for patients who do not have an indication for warfarin. Evidence

☐ Antithrombotic contraindicated:

Reasons to withhold Antithrombotic agents

☐ Allergy to or complication related to antithrombotic	☐ Intracranial surgery/biopsy	☐ Bleeding disorder
	☐ Planned surgery	☐ Peptic ulcer disease
☐ Rule out bleed	☐ Hemorrhage	☐ Other:_____
☐ Intolerance in past	☐ Bleeding risk	

☐ Aspirin 325 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 325 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 300 mg PR daily order if pt unable to take Po/NG.

☐ Aspirin 162 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 162 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 150 mg PR daily order if pt unable to take Po/NG.

☐ Aspirin 81 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 81 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 150 mg PR daily order if pt unable to take Po/NG.

☐ Clopidogrel (Plavix) 300 mg Po x 1 dose now as a loading dose.
☐ Clopidogrel (Plavix) 75 mg Po daily. Start 24 Hrs after 300 mg dose (if ordered).
☐ Aggrenox (aspirin 25 mg / dipyridamole 200 mg) 1 Tab Po BID.

Cardiac medications: Anti-hypertensives (Preferred Treatment) Evidence
☐ LaBETalol (Trandate) 20 mg IV Push over 2 min Q 10 mins Prn SBP > 220 or DBP > 120. If SBP remains > 220 or DBP remains > 120 after 60 mg, contact MD for alternative orders. Hold for HR < 50 and notify MD. Max total dose = 300 mg/24 Hrs.
☐ HydrALAZINE (Apresoline) 10 mg IV push over 2 mins Q 1 Hr Prn SBP > 220 or DBP > 120 if unable to give LaBETalol. ** For Critical Care, Med Tele, DSU and Cardiac Renal use only. DC when transferred out of these units.**
☐ LaBETalol (Trandate) 20 mg IV Push over 2 mins x 1 dose Prn SBP > 220 or DBP > 120 as a loading dose prior to starting a LaBETalol continuous IV infusion.
☐ LaBETalol (Trandate) 200 mg/200 mL NS continuous IV infusion, start at 2 mg/min and titrate by 0.5 – 1 mg/min Q 10 mins up to a max of 8 mg/min to maintain SBP < 220 or DBP < 120. Titrate down by 0.5-1 mg/min Q 15 mins. Hold for HR < 50 and notify MD. ** For Critical Care use only. DC when transferred out of Critical Care unit.**

Cardiac medications: Anti-hypertensives (Alternative Treatment) ***Physician to select ONE drug only**** Evidence
☐ Nitroprusside (Nipride) 50 mg/250 mL D5W continuous IV infusion, start at 0.5 mCg/Kg/min and titrate by 0.5 mCg/Kg/min Q 3 – 5 mins up to a max of 10 mCg/Kg/min to maintain SBP < 220 or DBP < 120. Titrate down by 0.5 – 0.75 mCg/Kg/min Q 15 mins. ** For Critical Care use only. DC when transferred out of Critical Care unit.**
☐ NiCARdipine (Cardene) 25 mg/250 mL NS continuous IV infusion, start at 5 mg/Hr and titrate by 2.5 mg/Hr Q 15 mins up to a max of 15 mg/Hr to maintain SBP < 220 or DBP < 120. Titrate down by 2.5 mg/Hr Q 15 mins. Hold for HR < 50 and notify MD. ** For Critical Care use only. DC when transferred out of Critical Care unit.**

Cardiac medications: Statins
☐ Statin Contraindication
Reasons to withhold Statin therapy
☐ Hepatic Failure ☐ Inflammatory Disease of liver ☐ No evidence of atherosclerosis
☐ Palliative Care ☐ Patient in Clinical Trial ☐ Medical Contraindication
☐ Patient refuses Treatment ☐ Rhabdomyolysis ☐ Statin Not Tolerated
☐ Simvastatin (ZoCOR) 20 mg Po daily in the evening

GI medications: Anti-emetics
☐ Ondansetron (Zofran) 4 mg IV Push Q 12 Hrs Prn N&V. If ineffective after 30 min, give proCHLORperazine if ordered. May give IM if no IV access.
☐ ProCHLORperazine (Compazine) 10 mg IV Push Q 6 Hrs Prn N&V. (If ondansetron Prn is also ordered, give ondansetron first. If ondansetron ineffective after 30 min, give proCHLORperazine as ordered.) May give IM if no IV access.

GI medications: Stress Ulcer Prophylaxis/Antacids ***Physician to select ONE regimen only****
☐ Famotidine (Pepcid) 20 mg Po BID. RN to contact Pharmacy to enter IV order (if ordered) if pt unable to take Po. Pharmacy to adjust per renal dosing protocol.
☐ Famotidine (Pepcid) 20 mg IV Push BID. RN to contact Pharmacy to enter Po order (if ordered) if pt is able to take Po. Pharmacy to adjust per renal dosing protocol.

GI medications: Laxatives/Stool Softeners/etc
☐ Docusate sodium (Colace) 100 mg Po BID. Hold for loose stools.
☐ Maalox Plus (aluminum/magnesium/simethicone) 30 mL Po Q 4 Hrs Prn indigestion. (product contains magnesium salts)

☐ Milk of Magnesia (MOM) 30 mL Po Q 6 Hrs Prn constipation. (product contains magnesium salts)
☐ Bisacodyl (Dulcolax) suppository 10 mg PR daily Prn constipation if Milk of Magnesia (MOM) (if ordered) not effective.
☐ Fleet enema adult 1 bottle (133 mL) PR daily Prn constipation if Milk of Magnesia (MOM) (if ordered) and Bisacodyl (Dulcolax) (if ordered) not effective. (product contains phosphate salts)

Endocrine medications: Diabetic Therapy
REMINDER: For Subcutaneous Insulin Orders - Use Subcutaneous Insulin Short Set/Order Form

Other medications:_____

***All labs/diagnostics will be drawn/done routine now unless otherwise specified**

LABORATORY - Cardiac Markers
☐ Troponin-I (TROP) - In AM

LABORATORY - Hematology
☐ Complete Blood Count (CBC) - In AM
☐ Erythrocyte Sediment Rate (ESR) - In AM

LABORATORY - Chemistry
☑ Lipid Profile (LPP) - In AM
☐ Basic Metabolic Panel (BMP) - In AM
☐ Comprehensive Metabolic Panel (CMP) - In AM
☐ Hemoglobin A1c - In AM
☐ Homocysteine, serum - In AM
☐ C Reactive Protein (CRP) - In AM
☐ Thyroid Stimulating Hormone (TSH) - In AM

LABORATORY – Coagulation
☐ Factor 2 Gene Mutation 20210 - In AM
☐ Hypercoagulation panel - In AM

LABORATORY – Immunology
☐ Anti Nuclear Antibody (ANA) - In AM
☐ Anti Phospholipid Syndrome (antibody) - In AM

LABORATORY - Serology
☐ Rapid Plasma Reagin (RPR) - In AM

DIAGNOSTICS - Cardiology
☐ 12-lead Electrocardiogram (EKG); Reason for exam: Ischemic Stroke
☐ Echocardiogram, transthoracic; Reason for exam: Ischemic Stroke

DIAGNOSTICS – Radiology
REMINDER: Avoid the routine use of a chest radiograph Evidence
☐ Chest 1 View X-ray (CXR) Portable; Reason: Ischemic Stroke Evidence
☐ Chest 2 View X-ray (CXR) Reason: Ischemic Stroke Evidence

DIAGNOSTICS - CT
☐ CT Angiography Neck with and without contrast. Reason: Ischemic Stroke
☐ CT Angiography Head with and without contrast. Reason: Ischemic Stroke

DIAGNOSTICS – MRI
REMINDER: If CT Angio of the brain/head was already done in ED MRA of the neck may not be indicated
☐ MRI Angiography Cerebral without contrast. Reason: Ischemic Stroke Evidence
☐ MRI Angiography, Neck carotid without contrast. Reason: Ischemic Stroke Evidence
☐ MRI Brain without contrast. Reason: Ischemic Stroke Evidence

DIAGNOSTICS – Ultrasonography
REMINDER: If CT Angio of the brain/head was already done in ED carotid ultrasound may not be indicated
☐ Ultrasound Carotid, Doppler, bilateral (VIH); Reason: Ischemic Stroke

MD CONSULTS
REMINDER: Consider Specialty Referral (i.e. Neurology, Cardiology) Evidence
☐ Consult MD_____
☐ Consult MD _____

REQUEST FOR SERVICE Evidence
☑ Consult Occupational Therapy for evaluation and treatment for activities of daily living (ADL)
☑ Consult Physical Therapy for evaluation and treatment for strengthening and mobility
☑ Consult Speech Therapy for swallow evaluation and treatment Evidence
☐ Consult Speech Therapy for speech evaluation and treatment
☑ PT Outpatient Physical Rehabilitation Referral
☐ Consult for Case Management
☐ Consult for Social Services
☐ Nutritional consult Evidence