### Hemorrhagic Stroke Orders

#### Phase 2

- **Pharmacy Mnemonic:** HSTROK1

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>1. Admit to ICU as inpatient for Dr. ____________________________</th>
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<tbody>
<tr>
<td></td>
<td><strong>CM: Stroke (Nursing order- do not delete)</strong></td>
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<tr>
<td></td>
<td>2. IV Access: Sodium Chloride 0.9% 1000ml at __________ ml/hr</td>
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<td>3. Vital Signs and Neuro Checks:</td>
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<td></td>
<td>(\quad\check) Continuous cardiac monitoring, every 1 hr x 24 hr, then every 2 hours more often as needed</td>
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<td>4. Diet: Keep NPO until nursing swallow screening completed and passed</td>
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<td>5. Seizure Precautions</td>
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<td>6. Nursing: Place SCDs for DVT prophylaxis</td>
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<td>7. Fall Precautions</td>
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<td>8. Activity:</td>
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<td></td>
<td>(\quad\check) Strict bed rest until rehab assessment per Physical Therapy then activity level as directed by PT</td>
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<tr>
<td></td>
<td>(\quad\check) No lifting or pulling of shoulder on affected side, HOB elevated 30 degrees, Turn every 2 hours</td>
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<td>9. Aspiration Precautions:</td>
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<td>10. Notify MD of Neurological changes</td>
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<td>11. Initiate Glycemic Control orders</td>
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<td>12. O2 via nasal cannula and face mask to keep SPO2 &gt;94%</td>
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<td>13. LABS: (Do not repeat if done in ED)</td>
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<tr>
<td></td>
<td>(\quad\check) CBC w/diff STAT once (\quad\check) Once daily x 3</td>
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<tr>
<td></td>
<td>(\quad\check) PT/INR STAT once (\quad\check) Once daily x 3</td>
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<tr>
<td></td>
<td>(\quad\check) Basic Metabolic Profile STAT once (\quad\check) Once daily x 3</td>
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<td></td>
<td>(\quad\check) Fasting Lipid Profile STAT once</td>
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<td></td>
<td>(\quad\check) Hgb A1C STAT once</td>
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<td></td>
<td>(\quad\check) UA STAT once (\quad\check) Urine C&amp;S STAT once</td>
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<tr>
<td></td>
<td>(\quad\check) Other _____________________________________</td>
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<tr>
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<td>14. Consults:</td>
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<td>(\quad\check) Pharmacy to identify and list home meds</td>
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<td></td>
<td>(\quad\check) Consult for Anticoagulation Team – Stroke Patient</td>
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<td></td>
<td>(\quad\check) Consult Nutrition Services for evaluation and dietary education – Stroke Patient</td>
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<td></td>
<td>(\quad\check) Consult Speech Therapy – Stroke Patient</td>
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<tr>
<td></td>
<td>(\quad\check) Consult Diabetic Nurse – (for diabetic patients only)</td>
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<td></td>
<td>(\quad\check) Consult Respiratory Therapy – Stroke Patient</td>
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<td></td>
<td>(\quad\check) Consult Social Services and Case Manager for discharge planning and Smoking Cessation</td>
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<td></td>
<td>(\quad\check) Consult Rehab Services: OT, PT, evaluate and treat - Stroke Patient OT:—include depression screen</td>
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<td>(\quad\check) Patient is ineligible to receive rehab services because symptoms resolved.</td>
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<td></td>
<td>(\quad\check) Call operator to initiate stroke alert.</td>
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</tbody>
</table>

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**Bottom Edge of Patient Label**

**Rev 10/15; SD40-3**
### Hemorrhagic Stroke Orders Phase 2

**Pharmacy Mnemonic:** HSTROKP2

#### 19. Diagnostics:

*Indication needed to process order

- [ ] MRI Brain & MRA Brain and Neck without contrast:  
  - *Indication*
- [ ] MRI Brain without contrast, without MRA:  
  - *Indication*
- [ ] CT of Brain without contrast for stroke:  
  - *Indication*
- [ ] CTA brain and neck for  
  - *Indication*
- [ ] Carotid Duplex Ultrasound for  
  - *Indication*
- [ ] Echocardiogram  
  - *Indication*
- [ ] Transcranial Doppler Daily  
  - *Indication*
- [ ] EEG  
  - *Indication*
- [ ] Other  
  - *Indication*

#### 20. Core Measures:

- [ ] Provide Stroke Education: Stroke Risk Factors, Stroke Warning Signs and Symptoms; FAST; How to Activate EMS: 911; Need for Follow up after Discharge; Prescribed Medications; Smoking Cessation; Diet Instructions
- [ ] Hunt and Hess Score (SAH):  
  - ____________
- [ ] ICH Score:  
  - ____________
- [ ] NIHSS 24 hours post endovascular procedure

#### 21. Medications:

**BP management:** **Goal is to maintain SBP < 140mm Hg and/or DBP < 105.**

- [ ] Normodyne, Trandate (Labetalol)  
  - 10mg  
  - 20 mg IV PRN SBP > 140. May repeat dose once in 4 hours if needed.
- [ ] Normodyne, Trandate (Labetalol) infusion 500mg in D5W 250ml, 2mg/min. Increase by 1 mg/min every 5 minutes to maintain goal. Max rate of 8 mg/hr. Max total dose 300 mg.
- [ ] Cardene (nicardipine) 20mg in sodium chloride 200mL. Begin infusion at 5mg/hr. Increase by 2.5 mg/hr every 15 min to maintain goal. Max rate is 15 mg/hr
- [ ] Nimotop (nimodipine) 60 mg po now and then every 4 hrs. Give 1 hr before meals. May be given SL or via NGT for Subarachnoid Hemorrhage.
- [ ] For ICH patients with admission INR greater than 1.4  
  - [ ] Vit K 10 mg in 50 ml NS IV infused over 10 min. STAT, then 5 mg PO daily for 2 days.
  - [ ] Give 2 units Fresh Frozen Plasma
  - [ ] Consult Hematology
- [ ] Pepcid (famotidine) 20 mg PO q12 hrs or IV q 12 hrs if unable to swallow Pharmacy to renally adjust
- [ ] Pepcid (famotidine) 20 mg PO daily if creatinine higher than 2 mg/dl Pharmacy to renally adjust
- [ ] Laxitive of Choice PRN constipation
- [ ] Zofran (ondansetron) 4mg IV every 6hrs PRN vomiting  
  - (Give 4mg IV Push over 2 to 5 minutes)
- [ ] Zofran (ondansetron) 4mg PO every 6hrs PRN vomiting
- [ ] Tylenol (acetaminophen) 325mg 2 tablets PO q 6 hrs PRN temp > 100.4° or for headache not to exceed 3 grams in 24 hours
- [ ] Tylenol (acetaminophen) 650 mg suppository per rectum q 6 hrs PRN temp > 100.4° or for headache not to exceed 3 grams in 24 hours

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**Signature:**  

__/_______________________________/__  

**Date** ____________  

**Time**__ ____________  

**Physician Signature**

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**DOCTOR'S ORDERS**

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**BOTTOM EDGE OF PATIENT LABEL**

**REV 10/15; SD40-3**
ST. DOMINIC-JACKSON MEMORIAL HOSPITAL
JACKSON, MISSISSIPPI
Nursing Swallow Screening Tool
(Dysphagia)

Part 1: Does the patient exhibit any of the following?

- Yes □ No □ Decreased consciousness
- Yes □ No □ Facial weakness or asymmetrical
- Yes □ No □ Tongue weakness or difficulty managing saliva
- Yes □ No □ Weak or absent cough and ability to clear throat on command
- Yes □ No □ Poor or absent voice
- Yes □ No □ Dysarthria (Slurred speech)
- Yes □ No □ Unable to follow simple commands
- Yes □ No □ Inability to handle own secretions

1. If “Yes” to ANY of the above, the patient has FAILED swallow (dysphagia) screen. STOP THE SCREENING and
   A. Keep the patient NPO
   B. Notify the physician that the patient has FAILED the dysphagia screen and
   C. Obtain orders to convert P.O. Meds to the appropriate alternate route.

2. If “No” to ALL of the above, complete Part 2 below

Part 2: PATIENT MUST BE SITTING UPRIGHT AT 90 DEGREE

With each step below watch for the following signs of swallowing difficulty (listed below):
changes to voice quality (wetness, gurgling) and/or coughing; drooling, oral holding, change in breathing, watery
eyes, runny nose, delayed coughing, throat clearing or no swallow reflex

At any step - STOP THE SCREENING. If ANY of the above occur, the patient has FAILED swallow (dysphagia) screen.

Step 1: Ask the patient to take one small sip of cranberry juice from a cup (no straw) □ Failed: Stop □ Passed: Proceed
Step 2: Have the patient slowly consume 4oz of cranberry juice from a cup (no straw), approximately 30 mL at a time over a 2 minute timeframe □ Failed: Stop □ Passed: Proceed
Step 3: Ask the patient to take a spoonful of applesauce □ Failed: Stop □ Passed: Proceed

RESULTS:

☐ The patient has FAILED this dysphagia screen:
   A. Keep the patient NPO
   B. Notify the physician that the patient has FAILED the dysphagia screen and
   C. Obtain orders to convert P.O. medications to the appropriate alternate route.

☐ The patient has PASSED this dysphagia screen:
   D. Notify the physician that the patient has PASSED the dysphagia screen, anticipate diet orders

Completed By: ___________________________ Date: ___________ Time: ___________