Canadian Stroke Best Practices Acute Stroke and Transient Ischemic Attack (TIA) Admission Order Set (Order Set 3)

Order set 3 is appropriate for admissions from the emergency department, direct inpatient admissions, strokes that occur after admission to hospital for another initial reason ("in-hospital strokes"), and as follow-up orders for stroke patients who have received tPA in the ED.

- Discontinue all previous stroke patient order sets

**Admission**

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<thead>
<tr>
<th>Option</th>
<th>Information</th>
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<tr>
<td>☑</td>
<td>Admit to stroke unit OR ☑ Admit to ID: ____________________________</td>
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<td>☑</td>
<td>Dr. ____________________________ to consult/assume MRP</td>
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**Diagnosis:**

- Does the patient have allergies or hypersensitivities? ☑ No ☑ Yes: Refer to allergy documentation and process

**Code Status:** ☑ Full Resuscitation ☑ DNR ☑ ________

**Next of kin:** ____________________________

**Phone number:** (______) __________________________

**Estimated length of stay:** ☑ less than 3 days ☑ 3 to 5 days ☑ 5 to 7 days ☑ _____ days

**Precautions**

- Contact - Reason: ________ ☑ Droplet- Reason: ____________ ☑ Airborne - Reason: ____________

**Stroke Symptom Onset Time**

- Obtain and record stroke symptom onset time (or time patient was last seen normal (LSN)/last known well LKW):  
  Document: Date of Onset/LSN: ____________ (dd/mm/yyyy) Time of onset/LSN: ____________ (hh:min)

**Consults**

- ☑ Stroke Neurologist/Stroke Team
- ☑ Neurosurgeon
- ☑ Physiatrist
- ☑ Palliative Care Team  ☑ Occupational Therapist (OT)  ☑ Speech Language Pathologist (SLP)
- ☑ Physiotherapist (PT)
- ☑ Dietitian
- ☑ Neuropsychologist  ☑ Pharmacist  ☑ Psychiatrist  ☑ Social Worker (SW)

**Swallowing Screening and Assessment**

- ☑ NPO until completion of Dysphagia Screening  ☑ Screen patient for swallowing ability and presence of dysphagia
  Document: Date: ____________ Time: ____________ Dysphagia screening result: __ Normal swallow, __ Abnormal swallow
- ☑ If swallowing screen is abnormal, refer patient to a SLP or OT for a detailed assessment, diet recommendations and therapy plan
  Document Referral Date: ____________ (dd/mm/yyyy)
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### Diet: Post Swallowing Assessment

- **☑ Upon completion of swallowing screen or assessment, initiate appropriate diet and texture**
  - Clear Fluids
  - Full Fluids
  - DAT
  - Healthy Heart
  - Diabetic (less than 1800 kCal)

### Modified Diet:

- Dysphagia Pureed Diet
- Dysphagia Thickened fluids
- Dental Soft
- Minced

- **MD to consider initiating enteral nutrition support (tube feeding) within 3 days of admission for a patient who is unable to meet nutritional requirements (NG tube not to be inserted within 24 hours of tPA administration)***
- Monitor hydration status

### Activity and Functional Assessments

- **☐ Activity as tolerated**
- **☐ Bed rest x _____ hours, then reassess**
- **☐ Elevate head of bed to 30 degrees**
- **☐ Mobilize patient as soon as possible once medically stable (side of bed, chair, ambulation)**
- **☐ Mobilize patients who received tPA when medically stable (side of bed, chair, ambulation)**

### Functional Assessments

- **☑ Assess patient for Falls Risk and reassess when changes in status occur**
- **☑ Rehabilitation assessment within 48 hours of patient admission**
- **☑ Complete AlphaFIM\(^{(R)}\) by Day 3 following admission**
- **☐ Complete an ADL assessment**

### Cognitive Assessments

- **☐ Assess patient for cognitive status using a validated tool (e.g., MoCA)**
- **☐ Assess patient for signs of depression, mood changes or changes in personality**
- **☐ Notify Stroke Team if any changes to mood or cognition**

### Vitals

- **☐ T, HR, RR, BP q _________ h**
- **☐ Pain Score q _________ h**
- **☐ If SBP greater than ________ mmHg or DBP greater than ________ mmHg for 2 or more readings taken 10 minutes apart, notify MD**

### Neurovitals

- **☐ Stroke severity assessment q _________ h**
  - National Institute of Health Stroke Scale (NIHSS) **or** Canadian Neurologic Scale (CNS) **or** GCS
  (NIHSS or CNS are preferred assessment tools)
- **☑ If any changes in neuro status or new/worsening signs and symptoms of stroke, notify Stroke Team STAT**

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**Submitted by:**

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**Practitioner:**

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### Monitoring
- Intake and Output
- Pressure Ulcer Risk Assessment/Skin assessment daily

### Respiratory
- O₂ flow rate at 2 – 6 L/minute by nasal cannulae (preferable) or at 5 – 10 L/minute by face mask
  - Titrate O₂ to achieve a target SpO₂ 93 - 96%
  - Titrate O₂ to achieve a target SpO₂ ______ to ______ %

**Patient with known chronically elevated PaCO₂**
- Titrate O₂ to achieve a target SpO₂ 88 - 92%
- Titrate O₂ to achieve a target SpO₂ ______ to ______ %
  - with O₂ flow rate at 1 - 2 L/minute by nasal cannulae or as per Venturi/Venti-mask package insert at 24 - 28%

### Lab Investigations (subsequent tests to be considered following patient arrival to ED)
- CBC
- Capillary Blood Glucose STAT
- Electrolytes
- CK
- AST, ALT, ALP
- Blood C + S x 3
- Hiv
- If female less than 50 years of age, serum β HCG

#### Additional Lab Investigations
- Cross + Type for 2 units packed red blood cells
- ABG
- Blood C + S x 3
- HIV
- If female less than 50 years of age, serum β HCG

**Reference Document Only**

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**Blood Glucose Monitoring/Glycemic Management**

- If first random blood glucose is greater than 10 mmol/L, repeat Blood Glucose
- **AND** Fasting Blood Glucose **X** HbA1C
- For diabetic patients, follow standard individual hospital diabetic protocol
  - Capillary Blood Glucose QID and PRN
  - Consult Diabetes Management Team **OR** Consult Endocrinologist
- Capillary Blood Glucose ___________________________ (frequency)

**Diagnostics**

- Chest X-Ray PA + Lateral - Reason: ___________________________
- 12-lead ECG daily for _________ days

**Neuro**

- CT Head Non Contrast at _________ days post admission - Reason: ___________________________ **OR**
- Diffusion Weighted MRI - Reason: ___________________________
- CT angiogram - Reason: ___________________________
- MR angiogram - Reason: ___________________________

**IV Therapy**

- 0.9% NaCl at _________ mL/h
  - **WITH** 20 mmol KCl/L
  - 40 mmol KCl/L
- ___________________________ at _________ mL/h
- Saline Lock and flush as per hospital Policy/Procedure

**Antithrombotic Therapy**

- No anticoagulants, No antithrombotics until CT completed and hemorrhage ruled out, and tPA eligibility determined

  ***MD to order at least 160 mg of acetylsalicylic acid (ASA) immediately as a one time loading dose after brain imaging has excluded intracranial hemorrhage***

- acetylsalicylic acid: _________ mg PO x 1 (only administer PO route after swallowing screen completed) given at: ________________ (Date/Time administered)

- If patient has swallowing difficulty, administer acetylsalicylic acid 325 mg PR OD

- Initiate maintenance antithrombotic therapy when CT/MRI has confirmed absence of hemorrhage (wait 24 hours post tPA administration)
  - acetylsalicylic acid 81 mg PO OD
  - clopidigrel 75 mg PO OD
  - extended-release dipyridamole 200 mg/acetylsalicylic acid 25 mg1 capsule PO BID

- ___________________________
### Antithrombotic Therapy for Stroke Patients with Atrial Fibrillation

- **Apixaban**
  - mg PO q h
- **Dabigatran**
  - mg PO q h
- **Rivaroxaban**
  - mg PO q h
- **Acetylsalicylic Acid**
  - mg PO q h
- **Warfarin**
  - Warfarin loading dose of mg PO daily for days,
  - Warfarin mg PO daily for days
  - Warfarin maintenance dose of mg PO daily
  - INR target range: (target 2.5 and range 2.0 - 3.0 for a majority of patients)
  - If on warfarin, INR daily until therapeutic range reached, then INR q days

### Bladder Management

- Avoid indwelling catheter
- Monitor patient for urinary incontinence or retention
  - If patient does not void spontaneously within 6 hours of admission, perform bladder scan
  - If bladder scan volume is greater than 300 mL, then catheterize in and out
  - Repeat bladder scan q4-6h
- Implement bladder-training program for patients with urinary incontinence or retention

### Bowel Management

- Monitor patient for persistent constipation and bowel incontinence
- Implement bowel management program for patients with persistent constipation and bowel incontinence

### Nausea/Vomiting Management

- Assess patient for presence of nausea with vitals and PRN
- **Dimenhydrinate** 25 – 50 mg PO/NG/IV/PR q4h PRN (use lowest possible for effect for elderly/frail)
- **Dimenhydrinate** 12.5 – 25 mg PO/NG/IV/PR/IM q4h PRN (use lowest possible for effect for elderly/frail)
- **Ondansetron** 4 mg PO/NG/IV q8h PRN. If not effective after 1 dose, notify MD
Document allergies on approved form and ensure medication reconciliation has been reviewed as per organizational process.

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### Pain/Fever Management

**Consider lowering the maximum daily dose of acetaminophen to 3,000 mg or less in 24 hours or, in patients at risk of hepatotoxicity with high doses e.g. chronic alcohol users, established liver disease, chronically malnourished***

- If acetaminophen ordered, **max from all sources mg in 24 hours (max 3,000 or 4,000 mg in 24 hours)**
- acetaminophen 650 mg PO/NG/PR q4h PRN for pain or if T greater than/equal to 37.5°C

### Patient and Family Education

- Assess patient and family for learning needs and readiness for information
- All team members to provide education to patient, family and caregivers throughout admission
- Provide discharge education and skills training to patient, family, and caregivers

### Discharge Plan

- Initiate discharge planning process
- **Expected Discharge to:**
  - Home or place of residence
  - Inpatient rehabilitation
  - Complex Continuing Care
  - Repatriate/transfer to other acute care: ________________________
  - Long Term Care
  - Palliative Care

- **Expected Discharge Referrals:**
  - Stroke Prevention Clinic
  - Outpatient rehabilitation
  - Palliative Care Team/Advanced Care Planning/ End-of-Life specialist
  - Home Care Services
  - Community-based rehabilitation

### Additional Orders

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Submitted by:  
Practitioner:  
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