Post-Endovascular Procedure Flowsheet

Access site checks every 15 minutes x4, then every 30 minutes x4 then hourly x 9. To be initiated at end of case

Utilize radial band area if applicable—document time the band was applied, side the band was applied to, amount of air withdrawn, and time band is removed. Refer to current hospital guideline.

☐ **Bedside access site check at hand-off** Lab RN _____ RN _____

Time Frame	Pre-Op	Post-Op	15 min	15 min	15 min	15 min	30 min	30 min	30 min	30 min	1 hour	1 hour	1 hour	1 hour	1 hour	1 hour	1 hour	1 hour
Date																		
Time																		
Pulse Location (Dorsalis Pedis/Posterior tibialis/popliteal/radial/brachial)																		
Approach assessment **L/R** Groin/radial																		
Radial band application/removal																		
Withdraw two mls of air every 15 minutes until pressure fully released if applicable																		
Dry & Intact																		
Pain																		
Oozing																		
Erythema																		
Swelling																		
Bruising																		
Temperature																		
Warm																		
Cool																		
Cold																		
Pulse																		
Present																		
Faint																		
Doppler Signal																		
Absent																		
Color																		
Normal																		
Pale																		
Cyanotic																		
Capillary Return																		
Brisk																		
Sluggish																		
Sensation																		
Present																		
Absent																		
RN Initials																		

Initial	Signature/Title	Initial	Signature/Title	Initial	Signature/Title

PT.

MR.#/RM.

DR.

Comprehensive Stroke Critical Care Flowsheet

Check one box according to order set being used:

- ☐ **Subarachnoid Hemorrhage:** SBP less than 140 mmHg/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.
- ☐ **Intracerebral Hemorrhage:** SBP 130–150 mmHg/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.
- ☐ **Acute Ischemic Stroke (no Alteplase):** SBP per Physician order/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.

		1 HRS	2 HRS	3 HRS	4 HRS	5 HRS	6 HRS	7 HRS	8 HRS	9 HRS	10 HRS	11 HRS	12 HRS
Time													
BP													
HR													
LOC Level of consciousness	0 = alert, keenly responsive 1 = not alert, arousable by minor stimulation 2 = not alert, arousable by pain 3 = reflex response, unresponsive, coma												
LOC Orientation	0 = answers month, age correctly 1 = answers only 1 question correctly 2 = answers neither correctly, coma												
LOC Commands	0 = performs 2 commands correctly 1 = performs 1 command correctly 2 = performs neither command correctly, coma												
Horizontal Gaze patient eyes to follow your finger or face	0 = normal eye movement all way to right & left **Deviates** 1 = gaze deviation but pupil crosses midline LT RT 2 = gaze deviation but pupil does not cross midline												
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic	0 = no visual field loss **Vision Loss** 1 = visual field loss in 1 quadrant LT RT 2 = visual field loss upper and lower quadrant Upper Lower 3 = bilateral visual field loss or blindness												
Facial Weakness smile, showing teeth, raise eyebrows, frown	0 = equal smile 1 = unequal smile, flattened nasal labial fold 2 = paralysis of lower face 3 = paralysis of upper and lower face												
Motor Arm arm raised by patient or examiner lifts up arm	0 = no drift at end of 10 seconds 1 = drifts down, does not hit bed by end of 10 seconds LT 2 = drifts & hits bed before 10 seconds 3 = arm moves on bed, no anti-gravity effort 4 = no movement RT x = untestable, amputation or fusion												
Motor Leg leg raised by patient or examiner	Test for 5 seconds Score same as motor arm LT RT												
Limb Ataxia finger to nose, heel down shin (score only if out of proportion to weaknesss)	0 = normal smooth movement or coma or unable to understand your command **Ataxia** LT RT 1 = present in 1 extremity, upper or lower Arm Leg 2 = present in both upper & lower extremity												
Sensory pin prick to face, arm and legs	0 = normal sensation **Sensory Loss** 1 = mild loss but aware of touch LT RT 2 = severe loss, unaware of touch, coma Face Arm Leg												
Best Language identify objects, read sentences, explain picture	0 = normal 1 = mild impairment 2 = severe, fragmented speech 3 = mute, no usable speech, coma												
Dysarthria repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words understandable 2 = severe, unintelligible, mute or coma												
Extinction / Neglect test double stimulation to vision and touch.	0 = no abnormality, coma, or aphasic **Neglect** 1 = present with touch or vision LT RT 2 = present with both touch & vision Touch Vision												
	TOTAL												
Complete Bedside Swallow Screen	**Dizziness** Y (yes) or N (no)												
	Double Vision Y (yes) or N (no)												
Document in Stroke Quality Documentation Band	**Nausea / vomiting** Y (yes) or N (no)												
	Headache Rate pain in box 0–10												
Notify physician of NIHSS increase of 4 or more points.	**Sx Intracranial Hemorrhage** Y (yes) or N (no)												
	Sx Angioedema Y (yes) or N (no)												
	Pupil Size Left/Right												
	Pupil Reaction Left/Right												
	INITIALS												

Signature _____ Signature _____ Signature _____

McLaren HEALTH CARE

673

PT.

MR.#/RM.

DR.

Comprehensive Stroke Critical Care Flowsheet

Check one box according to order set being used:

- ☐ **Subarachnoid Hemorrhage:** SBP less than 140 mmHg/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.
- ☐ **Intracerebral Hemorrhage:** SBP 130–150 mmHg/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.
- ☐ **Acute Ischemic Stroke (no Alteplase):** SBP per Physician order/Neuro checks and vital signs hourly/NIHSS once per shift unless there is neurological decline.

		13 HRS	14 HRS	15 HRS	16 HRS	17 HRS	18 HRS	19 HRS	20 HRS	21 HRS	22 HRS	23 HRS	24 HRS
Time													
BP													
HR													
LOC Level of consciousness	0 = alert, keenly responsive 1 = not alert, arousable by minor stimulation 2 = not alert, arousable by pain 3 = reflex response, unresponsive, coma												
LOC Orientation	0 = answers month, age correctly 1 = answers only 1 question correctly 2 = answers neither correctly, coma												
LOC Commands	0 = performs 2 commands correctly 1 = performs 1 command correctly 2 = performs neither command correctly, coma												
Horizontal Gaze patient eyes to follow your finger or face	0 = normal eye movement all way to right & left **Deviates** 1 = gaze deviation but pupil crosses midline LT RT 2 = gaze deviation but pupil does not cross midline												
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic	0 = no visual field loss **Vision Loss** 1 = visual field loss in 1 quadrant LT RT 2 = visual field loss upper and lower quadrant Upper Lower 3 = bilateral visual field loss or blindness												
Facial Weakness smile, showing teeth, raise eyebrows, frown	0 = equal smile 1 = unequal smile, flattened nasal labial fold 2 = paralysis of lower face 3 = paralysis of upper and lower face												
Motor Arm arm raised by patient or examiner lifts up arm	0 = no drift at end of 10 seconds 1 = drifts down, does not hit bed by end of 10 seconds LT 2 = drifts & hits bed before 10 seconds 3 = arm moves on bed, no anti-gravity effort 4 = no movement RT x = untestable, amputation or fusion												
Motor Leg leg raised by patient or examiner	Test for 5 seconds LT Score same as motor arm RT												
Limb Ataxia finger to nose, heel down shin (score only if out of proportion to weaknesss)	0 = normal smooth movement or coma or unable to understand your command **Ataxia** LT RT 1 = present in 1 extremity, upper or lower Arm Leg 2 = present in both upper & lower extremity												
Sensory pin prick to face, arm and legs	0 = normal sensation **Sensory Loss** 1 = mild loss but aware of touch LT RT 2 = severe loss, unaware of touch, coma Face Arm Leg												
Best Language identify objects, read sentences, explain picture	0 = normal 1 = mild impairment 2 = severe, fragmented speech 3 = mute, no usable speech, coma												
Dysarthria repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words understandable 2 = severe, unintelligible, mute or coma												
Extinction / Neglect test double stimulation to vision and touch.	0 = no abnormality, coma, or aphasic **Neglect** 1 = present with touch or vision LT RT 2 = present with both touch & vision Touch Vision												
	TOTAL												
Complete Bedside Swallow Screen	**Dizziness** Y (yes) or N (no)												
	Double Vision Y (yes) or N (no)												
Document in Stroke Quality Documentation Band	**Nausea / vomiting** Y (yes) or N (no)												
	Headache Rate pain in box 0–10												
Notify physician of NIHSS increase of 4 or more points.	**Sx Intracranial Hemorrhage** Y (yes) or N (no)												
	Sx Angioedema Y (yes) or N (no)												
	Pupil Size Left/Right												
	Pupil Reaction Left/Right												
	INITIALS												

Signature _____ Signature _____ Signature _____

PT.

MR.#/RM.

DR.

McLaren Health Care

ISCHEMIC STROKE & CRITICAL CARE FLOW SHEET
NURSES NOTES

Date:

PT.

MR.#/RM.

DR.