Thrombolytic BP Parameters: < 180/105

## **Comprehensive Stroke Thrombolytic Flowsheet**

Thrombolytic Time Ou Thrombolytic:	Bolusn	Time: ng Time:	Baseline of Thron	w/in 15 min	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	30 MIN
0.9 NaCl Flush 10 ml T	ime:		Time									
Q 1 hour x 16 hours		x 2 hours, Q 30 min x 6 hours,	BP									
Complete Bedside Swall Document in Stroke Qua		ntation Band	HR									
Level of consciousness	1 = not alert, 2 = not alert,	nly responsive arousable by minor stimulation arousable by pain ponse, unresponsive, coma	l									
LOC Orientation	1 = answers	month, age correctly only 1 question correctly neither correctly, coma										
LOC Commands	1 = performs	2 commands correctly 1 command correctly neither command correctly, coma										
Horizontal Gaze patient eyes to follow your finger or face	1 = gaze devi 2 = gaze devi	ye movement all way to right & left iation but pupil crosses midline iation but pupil does not cross midline	<b>Deviates</b> LT RT									
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic	2 = visual fiel		sion Loss LT RT er Lower									
Facial Weakness smile, showing teeth, raise eyebrows, frown	2 = paralysis	smile, flattened nasal labial fold										
Motor Arm	1 = drifts dow	n, does not hit bed by end of 10 secor	nds LT									
arm raised by patient or examiner lifts up arm	3 = arm move 4 = no mover	no drift at end of 10 seconds drifts down, does not hit bed by end of 10 seconds drifts & hits bed before 10 seconds arm moves on bed, no anti-gravity effort no movement 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 weakness)	unable to 1 = present ir	nooth movement or coma or understand your command a 1 extremity, upper or lower a both upper & lower extremity	<b>Ataxia</b> LT RT Arm Leg									
<b>Sensory</b> pin prick to face, arm and legs		but aware of touch	sory Loss LT RT Arm Leg									
Best Language identify objects, read sentences, explain picture		nirment agmented speech usable speech, coma										
<b>Dysarthria</b> repeat tip top, 50/50, huckleberry, baseball player, mama		o slurring oderate slurring but some words under: nintelligible, mute or coma	standable									
<b>Extinction / Neglect</b> test double stimulation to vision and touch.	1 = present w	vith touch or vision	Neglect LT RT ch Vision									
Thrombolytic Complication if suspected, alert order			TOTAL									
provider or Med Control			s) or N (no)									
ambulance.			es) or N (no)									
Angioedema: swelling	of tongue,		es) or N (no)									
lips, mouth or throat, dif		*	in box 0-10						1	<u> </u>		ļ
breathing.			es) or N (no)			<u> </u>	1	1	1			<u> </u>
Intracranial Hemorrha decrease level of conso		•	es) or N (no)		<del>                                     </del>	<b>-</b>	<del>                                     </del>	ļ	<del>                                     </del>			
N&V, change in NIHSS	,	Pupil Size Left/Right Pupil Reaction Left/Right										
,		Publi Reaction Left/Right										

N&V, greate heada

on and todon.	z = present w	TITI DOTTI TOUCTI & VISIOTI	TOUCH VISION						
rombolytic Complic			TOTAL						
uspected, alert ordering vider or Med Control if in		Dizziness	Y (yes) or N (no)						
bulance.	11 111	Double Vision	Y (yes) or N (no)						
gioedema: swelling	of tonque.	Nausea / vomiting	Y (yes) or N (no)						
s, mouth or throat, diff		Headache	Rate pain in box 0-10						
, mouth or throat, difficulty athing.	Sx Intracranial Hemorrhag	e Y (yes) or N (no)							
racranial Hemorrha	ge (ICH):	Sx Angioedema	Y (yes) or N (no)						
crease level of consci	,	Pupil Size Left/Right							
V, change in NIHSS		Pupil Reaction Left/Righ	nt						
ater, abrupt rise in BP adache, pupillary chan			INITIALS						
ignature		Signature			Sian	ature			

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or Med Control if in amb		Date	30 MIN								
<b>Angioedema:</b> swelling of breathing.	of tongue, lips, mouth or throat, difficulty	Time									
Intracranial Hemorrhad	ge (ICH): decrease level of consciousness,	BP									
	4 or greater, abrupt rise in BP, new										
headache, pupillary cha	nges	HR									
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										
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 1 = gaze deviation but pupil crosses midline 2 = gaze deviation but pupil does not cross midline	<b>Deviates</b> LT RT									
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic		sion Loss LT RT er Lower									
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	0 = no drift at end of 10 seconds 1 = drifts down, does not hit bed by end of 10 secon 2 = drifts & hits bed before 10 seconds	nds LT									
examiner lifts up arm	3 = arm moves on bed, no anti-gravity effort 4 = no movement x = untestable, amputation or fusion	RT									
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 weakness)	0 = normal smooth movement or coma or unable to understand your command 1 = present in 1 extremity, upper or lower 2 = present in both upper & lower extremity	Ataxia LT RT Arm Leg									
Sensory pin prick to face, arm and legs	1 = mild loss but aware of touch	sory Loss LT RT 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	J									
<b>Dysarthria</b> repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words under 2 = severe, unintelligible, mute or coma	standable									
Extinction / Neglect test double stimulation to vision and touch.	'	Neglect LT RT ch Vision									
		TOTAL									
	Dizziness Y (ye	s) or N (no)									
		s) or N (no)									
	Nausea / vomiting Y (ye	s) or N (no)									
		in box 0-10									
		es) or N (no)									
	-	s) or N (no)									
	Pupil Size Left/Right Pupil Reaction Left/Right										
	r upii Neaction Leit/Nignt	INITIALS									
Signature	Signature				Signa	ature	J		<u> </u>		

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Thrombolytic Complic or Med Control if in aml	nations: if suspected, alert ordering provider bulance	Date	30 MIN	30 MIN	9 HRS	10 HRS	11 HRS	12 HRS	13 HRS	14 HRS	15 HRS
	of tongue, lips, mouth or throat, difficulty	Time									
breathing. Intracranial Hemorrha N&V, change in NIHSS	ge (ICH): decrease level of consciousness, 4 or greater, abrupt rise in BP, new	BP									
headache, pupillary cha		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 1 = gaze deviation but pupil crosses midline 2 = gaze deviation but pupil does not cross midline	<b>Deviates</b> LT RT									
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic		sion Loss LT RT er Lower									
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	0 = no drift at end of 10 seconds 1 = drifts down, does not hit bed by end of 10 secon	nds LT									
examiner lifts up arm	2 = drifts & hits bed before 10 seconds 3 = arm moves on bed, no anti-gravity effort 4 = no movement x = untestable, amputation or fusion	RT									
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 weakness)	2 = present in both upper & lower extremity	Ataxia LT RT Arm Leg									
Sensory pin prick to face, arm and legs	1 = mild loss but aware of touch 2 = severe loss, unaware of touch, coma Face	sory Loss LT RT 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										
<b>Dysarthria</b> repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words under 2 = severe, unintelligible, mute or coma	standable									
Extinction / Neglect test double stimulation to vision and touch.	1 = present with touch or vision	Neglect LT RT									
noion and todon.		ch Vision									
		TOTAL									
		s) or N (no)	1		-						
		s) or N (no)	1		-						
		s) or N (no)									
		in box 0-10			-						
		es) or N (no)									
		s) or N (no)			<b>_</b>						
	Pupil Size Left/Right										
	Pupil Reaction Left/Right	INITIALS									
		INITIALS	<u> </u>		<u> </u>			<u> </u>			



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Signature\_

\_ Signature\_

or Med Control if in amb	cations: if suspected, alert ordering provider bulance of tongue, lips, mouth or throat, difficulty		HRS								
breathing.		Time									
Intracranial Hemorrhag	ge (ICH): decrease level of consciousness, 4 or greater, abrupt rise in BP, new	BP									
headache, pupillary cha	nges	HR									
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	<u> </u>									
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	<b>Deviates</b> T RT									
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic	<u> </u>										
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 second 2 = drifts & hits bed before 10 seconds 3 = arm moves on bed, no anti-gravity effort 4 = no movement x = untestable, amputation or fusion	ls LT									
Motor Leg leg raised by patient or examiner	Test for 5 seconds Score same as motor arm	LT									
Limb Ataxia finger to nose, heel down shin (score only if out of proportion to weakness)		Ataxia .T RT rm Leg									
Sensory pin prick to face, arm and legs		ory Loss T RT rm Leg									
Best Language identify objects, read sentences, explain picture	0 = normal 1 = mild impairment 2 = severe, fragmented speech 3 = mute, no usable speech, coma										
<b>Dysarthria</b> repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words underst 2 = severe, unintelligible, mute or coma	andable									
Extinction / Neglect test double stimulation to vision and touch.	0 = no abnormality, coma, or aphasic 1 = present with touch or vision	leglect T RT n Vision									
	1	OTAL									
		or N (no)									
		or N (no)									
		or N (no)									
	Headache Rate pain in										
	Sx Intracranial Hemorrhage Y (yes	or N (no)									
	Sx Angioedema Y (yes)	or N (no)									
	Pupil Size Left/Right										
	Pupil Reaction Left/Right										

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## ISCHEMIC STROKE & CRITICAL CARE FLOW SHEET NURSES NOTES

Date:	
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## 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.

□Be	dside access site	chec	k at h	nand-	off	Lab	RN						RN _					_		
Time	Frame	Pre-Op	Post-Op	15 min	15 mir	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	1 hou
Date																				
Time																				
(Dorsa	e Location alis Pedis/Posterior /popliteal/radial/brachial)																			
	each assessment <b>L/R</b> /radial																			
Radial I	pand application/removal																			
15 min	aw two mls of air every utes until pressure fully ed if applicable																			
Dry &	Intact																			
Pain																				
Oozin	ıg																			
Eryth	ema																			
Swell	ing																			
Bruisi	ng																			
Temp	erature																			
Warm	1																			
Cool																				
Cold																				
Pulse	)																			
Prese	ent																			
Faint																				
Dopp	ler Signal																			
Abser	nt																			
Color																				
Norm	al																			
Pale																				
Cyan	otic																			
Capil	lary Return																			
Brisk	-																			
Slugg	ish																			
Sens																				
Prese																				
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RN In																				
	Signature/Title			· Ir	nitial	Signat	ture/T	itle				Initi	al Si	gnatur	e/Title	)				

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