

(Acct:

CSN:

(82y.o. F) PCP: MOORE, D (586-447-

0236B

Patient Care Timeline (5/21/2017 10:35 to 5/21/2017 13:15)

5/21/2017	Event		User
10:35	Patient arrived in ED		Jones, Christina J
10:35:09	Patient expected in ED		Jones, Christina J
10:36:15	Patient roomed in ED To room 0102A		Jones, Christina J
10:36:21	Assign Attending Sadzikowski, Mark R, MD assigned as Attending		Korpal, Ryan
10:36:21	Team Member Assigned Korpal, Ryan assigned as ED Scribe		Korpal, Ryan
10:36:24	Assign EC Physician		Korpal, Ryan
10:36:24	ED Provider First Contact Initial patient evaluation performed		Korpal, Ryan
10:36:31	ED Provider Notes Chief Complaint: R sided weakness		Sadzikowski, Mark R, MD

HPI

10:37 AM A 82-year-old female who is 82y.o. presents to the ED on 5/21/2017 complaining of R sided weakness. PMH include HTN, HLD, and asthma. She arrived via EMS; blood pressure 150/90. Pt's daughter is present in the ED. Daughter states this morning the pt woke her up, had a conversation, and proceeded to get the adult son bathed and changed. At approximately 10:10AM this morning the pt was kneeling on the floor, changing her son's adult diaper, with her daughter present, when the daughter noted the pt's R arm became weak and started experiencing difficulty with speaking. Denies any R leg weakness. Daughter described the pt's speech as "mumbled" and "gurgled." Associated symptoms include R sided facial droop. Denies being on any blood thinners at this time. Pt and daughter deny any pain anywhere, fever, chills, nausea, vomiting, abdominal pain, chest pain, palpitations or SOB. Denies any recent surgeries. Denies any recent trauma or falls. Denies any hx of stomach ulcers. Pt denies any other symptoms and modifying factors.

Physician: Moore, Donald R, MD**Review of Systems**

Constitutional: Negative for fever and chills.

HENT: Negative for ear pain and sore throat.

Respiratory: Negative for cough and shortness of breath.

Cardiovascular: Negative for chest pain, palpitations and leg swelling.

Gastrointestinal: Negative for nausea, vomiting, abdominal pain and diarrhea.

Genitourinary: Negative for dysuria and frequency.

Musculoskeletal: Negative for myalgias and back pain.

Neurological: Positive for facial asymmetry (R sided facial droop), speech difficulty and weakness (R arm). Negative for dizziness and headaches.

Psychiatric/Behavioral: The patient is not nervous/anxious.

All other systems reviewed and are negative.

Patient's Medications**New Prescriptions**

No medications on file

Previous Medications

ALBUTEROL 108 (90 BASE) MCG/ACT INHAL AERO SOLN	inhale 2 Puffs into the lungs every 4 hours as needed for FOR SHORTNESS OF BREATH.
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AMLODIPINE (NORVASC) 5 MG PO TAB	take 1 Tab by mouth once daily.
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ASPIRIN 325 MG PO TAB	take 81 mg by mouth once daily.
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ATENOLOL-CHLORTHALIDONE (TENORETIC) 50-25 MG PO TAB	take 1 Tab by mouth once daily.
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CALTRATE 600 PO	take by mouth once daily.
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CENTRUM SILVER PO TAB	take 1 Tab by mouth once daily.
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DIPHENOXYLATE-ATROPINE (LOMOTIL) 2.5-0.025 MG PO TAB	take 1 Tab by mouth as needed for FOR DIARRHEA.
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GLUCOSAMINE 500 MG PO CAP	take by mouth once daily.
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MOMETASONE FURO-FORMOTEROL FUM (DULERA) 100-5 MCG/ACT INHAL AEROSOL	inhale 2 Puffs into the lungs twice daily.
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MULTIPLE VITAMINS-MINERALS (OCUVITE ADULT FORMULA) PO CAP	take by mouth once daily.
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Modified Medications

No medications on file

Discontinued Medications

No medications on file

No Known Allergies

Past Medical History

Diagnosis Date

- Bradycardia 2/4/2010

- Osteoarthritis of knee 2/4/2010

- Angioneurotic edema 2/4/2010

- Postmenopausal 2/4/2010
 - Fatigue 2/4/2010
 - Bilateral cataracts
 - Hyperlipidemia 2/4/2010
 - Hypertension 2/4/2010
echo/doppler 03/18/15
 - Pneumonia
 - Arthritis
 - Positive TB test
 - Asthma
- cold air, exertional*

No past surgical history on file.

Social History

Social History

- | | |
|-----------------------|---------|
| • Marital Status: | Married |
| Spouse Name: | N/A |
| • Number of Children: | N/A |
| • Years of Education: | N/A |

Social History Main Topics

- | | |
|----------------------|---|
| • Smoking status: | Never Smoker |
| • Smokeless tobacco: | Never Used |
| • Alcohol Use: | 0.5 oz/week
1 Glasses of wine per week |
| • Drug Use: | No |
| • Sexual Activity: | Not on file |

Other Topics

- | | |
|------------|---------------|
| • Exercise | Concern
No |
|------------|---------------|

Social History Narrative

Family History

Problem	Relation	Age of Onset
• Heart	Mother	
• Heart	Father	
• Hypertension	Father	

There were no vitals taken for this visit.

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. She is active. No distress.

Pt is awake and answering questions with a slurred speech.

HENT:

Head: Normocephalic and atraumatic.

Nose: Nose normal.

Mouth/Throat: Uvula is midline, oropharynx is clear and moist and mucous membranes are normal.

Right sided facial droop is noted. Gag reflex is present but diminished.

Eyes: Conjunctivae, EOM and lids are normal. No scleral icterus.

Eyes- minimally reactive to light. Sclera is clear and conjunctiva is pink. ROM of the eyes is within normal limits.

Neck: Normal range of motion and full passive range of motion without pain. Neck supple.

Cardiovascular: Normal rate, regular rhythm, S1 normal, S2 normal and normal heart sounds. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. Normal appearance and bowel sounds are normal. There is no tenderness. There is no rebound and no guarding.

Musculoskeletal: She exhibits no edema or tenderness.

Extremities- Decreased strength noted to the RUE. Normal strength to the LUE and lower extremities. Decreased sensation noted to the RUE.

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time. She is not disoriented. A sensory deficit is present. No cranial nerve deficit. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.

NIH score: 7.

Skin: Skin is warm and dry. She is not diaphoretic. No erythema.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Her speech is slurred.

Nursing note and vitals reviewed.

NIH Stroke Scale

Interval: Baseline

Time: 10:37 AM

Person Administering Scale: Dr. Sadzikowski

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

1 Level of 0=alert; keenly responsive
a conscious
 ness:
1 LOC 0=Answers both questions correctly
b.questions
 :
1 LOC 0=Performs both tasks correctly
c.command
 s:
2.Best 0=normal
 Gaze:
3.Visual: 0=No visual loss
4.Facial 2=Partial paralysis (total or near total paralysis of the lower face)
 Palsy:
5 Motor left 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
a.arm:
5 Motor 2=Some effort against gravity, limb cannot get to or maintain (if cured) 90 (or 45)
b.right arm: degrees, drifts down to bed, but has some effort against gravity
6 motor left 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
a.leg:
6 Motor 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
b right leg:
7.Limb 0=Absent
 Ataxia:
8.Sensory: 1=Mild to moderate sensory loss; patient feels pinprick is less sharp or is dull on the
 affected side; there is a loss of superficial pain with pinprick but patient is aware She is
 being touched
9.Best 1=Mild to moderate aphasia; some obvious loss of fluency or facility of comprehension
 Language without significant limitation on ideas expressed or form of expression.
 :
1 Dysarthri 1=Mild to moderate, patient slurs at least some words and at worst, can be understood
0.a: with some difficulty
1 Extinction0>No abnormality
1.and
Inattentio
n:

Total: 7

Stroke Target Times

Last Known Well Date and Time -- 10:10AM this morning

NIH Stroke Score - 7

Thrombolytics used - Yes

Thrombolytic/Intervention Assessment:

Patient is a candidate for thrombolytic therapy in the 0-3 hour window

Patient is a candidate for thrombolytic therapy in the 3-4.5 hour non-FDA approved window, which requires signed consent.

NIH Stroke Scale

Interval: S/p TPA

Time: 11:58 AM

Person Administering Scale: Dr. Sadzikowski

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

1 Level of consciousness:
 a. LOC 0=alert; keenly responsive
 b. questions :
 1 LOC 0=Answers both questions correctly
 c. command :
 1 LOC 0=Performs both tasks correctly
2.Best Gaze:
 3.Visual: 0=No visual loss
 4.Facial Palsy:
 5 Motor left 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
 a.arm: 5 Motor 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
 b.right arm: 6 motor left 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
 a.leg: 6 Motor 0=No drift, limb holds 90 (or 45) degrees for full 10 seconds
 b right leg: 7.Limb 0=Absent
Ataxia:
 8.Sensory: 0=Normal; no sensory loss
 9.Best 1=Mild to moderate aphasia; some obvious loss of fluency or facility of comprehension Language without significant limitation on ideas expressed or form of expression.
 1 Dysarthri 1=Mild to moderate, patient slurs at least some words and at worst, can be understood
 0.a: with some difficulty
 1 Extinction 0=No abnormality
 1.and Inattention
 n:
Total: 4

No results found for this visit on 05/21/17.

I have reviewed the following:
 All lab and radiology studies performed

I have interpreted the following:
 Pulse Ox:
 Reason: Other R sided weakness
 Result: 100% on nasal cannula
 Impression: Normal

10:57 AM
 ECG: Other Sinus bradycardia Rate: 52 bpm
 Rhythm Strip:
 Reason: R sided weakness
 Rhythm: Sinus bradycardia
 Rate: 52 bpm
 Impression: Sinus bradycardia

ED Course:
11:03 AM Pt reevaluated. Pt's symptoms are still not improved. Pt denies being on any blood thinners at this time. Pt denies any hx of ulcers or recent surgeries. I have explained to the family and pt the complications of severe bleeding in the brain or elsewhere with TPA. Pt and daughter consented to the use of TPA.

11:57 AM Pt reevaluated. Pt reports of an improvement in speech and weakness s/p TPA. At this time, repeat NIH score is a 4.

12:34 PM Pt reevaluated. Pt is resting comfortably in no acute distress. Discussed with family plan of care and they are in agreement. All questions have been answered at this time.

Discussed Case with:

10:56 AM Discussed case with Dr. Jain (radiology) who denies seeing any bleeding on a CT scan of the head/brain.
11:01 AM Discussed case with Dr. Aboukasm; Neurologist on-call, who said we can administer TPA if the family and pt consent to it.
11:22 AM Discussed case with Dr. Almasri, who is covering for Dr. Moore, who agrees with the plan of care and accepts the admit.
12:00 PM Discussed case with Dr. Aboukasm who is present at bedside to examine the pt. He would like the pt admitted to a monitored stroke unit floor.

Medical Decision Making:

The patient presented to the ED today with new right sided weakness and slurred speech. They were worked up for this in the ED. Code stroke was called out and pt was immediately taken to CT scan. Initial CT scan w/o contrast was read by Dr. Jain who called me stating there was no sign of an intracranial bleed. Stroke Neurologist on call; Dr. Aboukasm, was paged and case was discussed with him. He said TPA may be administered if family and pt consent to it. Risks and benefits of TPA were discussed in great detail with family and pt, and they opted into the TPA treatment. On arrival, Initial NIH stroke score was 7 and improved to 4 s/p TPA treatment. Pt is much improved during her stay in the ED. They will be admitted to the hospital at this time under the care of Dr. Almasri with a consult from Dr. Aboukasm. The patient is agreeable to this plan and all questions have been answered at this time.

My decision to admit, with the expectation of a minimal two midnight duration of stay, is based on complex medical factors such as their past medical history. The severity of their signs and symptoms, specifically RUE weakness, facial asymmetry and slurred speech. Current therapeutic and/or diagnostic interventions planned including neurology consultation. The risk of an adverse event occurring during the time period for which hospitalization is considered such as CVA and/or cardiopulmonary decompensation.

I, Dr. Sadzikowski, provided critical care. The failure to initiate these interventions on an urgent basis would likely (high probability) result in sudden, clinically significant or life threatening deterioration in the patient's condition. All critical care time is in addition to any procedures, teaching, or resident work performed. Critical care time was spent at the bedside, reviewing test(s), and discussing care with staff. Critical care time spent was 30 minutes. The organ system(s) / conditions impaired: Neurology.

Disposition: Admit

Final Impression: 1) New onset of slurred speech and R sided weakness; probable CVA
 2) TPA treatment with marked clinical improvement

Core Measure

No diagnosis found.

There are no hospital problems to display for this patient.

Midlevel Provider

No providers found

Resident Provider

No providers found

Attending Provider: Sadzikowski, Mark R, MD

Ryan Korpala acting as Scribe for Dr. Sadzikowski

10:40	ED Nurse Notes Addendum	Patient presents via EMS from home. Patient able to answer questions by shaking head yes or no but is unable to speak at this time. Mumbled noises noted when patient attempts to verbally answer questions. Daughter at bedside stated mother normally A&Ox3, performs ADL's self. Daughter stated at about 1010 today, mother began to shake right arm, became confused, and was unable to speak so daughter called EMS. Right sided weakness to right arm and right sided facial droop noted. Patient placed on monitor, continuous pulse ox, and BP. Code Stroke initiated prior to patients arrival. Patient shakes head no to headache, dizziness, SOB, and pain. Dr. Sadzikowski at bedside.	Meier, Brooke Ashley, RN
10:40	Pre-Hospital Treatment	Pre-Hospital Treatment - Pre-Hospital Treatment: Yes	Meier, Brooke Ashley, RN
10:40	Triage Start	Pre-Hospital Treatment - See EMS Report: Yes Triage Start - Begin Triage: Yes	Meier, Brooke Ashley, RN
10:42	ED Nurse Notes	To CT via stretcher with RN, Tech, and monitor. No change in status.	Meier, Brooke Ashley, RN
10:42	Vitals ED	Vital Signs - BP: 95/77 mmHg ; Heart Rate : 53 ; Resp: 18 ; Temp: 97.1 °F (36.2 °C) ; Temp Source: Oral ; SpO2: 100 % ; FIO2 %: 21 % Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Motor Response: Obeys verbal command Pain Scale / Interventions - Pain Score: 0 (shakes head yes or no)	Meier, Brooke Ashley, RN
10:42	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 83 ; Shock Index (Read only): 0.6 Relevant Labs and Vitals - Temp (in Celsius): 36.2	Meier, Brooke Ashley, RN
10:43:41	Imaging Started	CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST, PORTABLE 1 VIEW CHEST	Sadzikowski, Mark R, MD
10:43:41	Orders Placed	COMPLETE BLOOD COUNT W DIFF ; PROTOME AND APTT ; COMPREHENSIVE METABOLIC PANEL (CMP) ; TROPONIN I ; THYROID STIMULATING HORMONE (TSH) ; ECG ; HARDWIRE MONITOR ; PORTABLE 1 VIEW CHEST ; CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST	Sadzikowski, Mark R, MD
10:44:19	Rad Arrival	CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST	Russell, Jenny Crisher, Claire S
10:44:51	Rad Arrival	PORTABLE 1 VIEW CHEST	Meier, Brooke Ashley, RN
10:45	Neurological	Neurological - Neurological: X ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Incomprehensible speech; Slurred speech ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Weak; 4 (active movement against gravity and some resistance – cannot resist examiner) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full	Meier, Brooke Ashley, RN

		resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; 4 (active movement against gravity and some resistance – cannot resist examiner) ; Neuromuscular Response LLE: Spontaneous and purposeful; 5 (active movement against full resistance without evident fatigue – normal) ; Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right	
10:45	Respiratory / Cough / Sputum	Respiratory - Respiratory Pattern: Regular and unlabored ; Respiratory Position: Position does not affect breathing ; Chest Assessment: Chest expansion symmetrical	Meier, Brooke Ashley, RN
10:45	Cardiac / Telemetry	Cardiac - Cardiac: X	Meier, Brooke Ashley, RN
10:45	Skin / Mucousal Membrane	Cardiac - Cardiac Rhythm : Sinus bradycardia	Meier, Brooke Ashley, RN
10:45	General Appearance	Skin - Color: Appropriate	Meier, Brooke Ashley, RN
10:45	ED Nurse Notes	Appearance - General Appearance: No Acute Distress; Alert; Tearful ; Level of Consciousness: Alert Functional Screening - ADL Prior to Adm: Performed independently ; Current Ambulation Level: Ambulates independently	Meier, Brooke Ashley, RN
10:50		Returned from CT to EC via stretcher with RN, Tech, and monitor. No change in status. Patient shaking head no to having pain. Speech still mumbled when attempting to answer questions.	Meier, Brooke Ashley, RN
10:52:29	Imaging Started	CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST	Russell, Jenny
10:53:56	Imaging Ended	CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST	Russell, Jenny
11:00	Travel Screening	TRAVEL SCREENING - Have you traveled outside the USA or has family or friends you live with traveled outside the USA in the past 21 days (3 weeks)?: No	Meier, Brooke Ashley, RN
11:00	Swallow Screening	Nursing Swallow Screening - "Are there past or present signs or symptoms of stroke, TIA or neurological impairment?": Yes ; Is patient alert, cooperative, and able to follow simple commands?: Yes ; Adult nursing swallow screen for the administration of oral medication: Unable to Perform	Meier, Brooke Ashley, RN
11:00:08	CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST Resulted	No components filed Collected: 5/21/2017 10:57 Last updated: 5/21/2017 11:05 Status: Final result	Interface, Radiology
11:01:42	Triage Started		Meier, Brooke Ashley, RN
11:01:59	Chief Complaints Updated	+ CVA-Weakness	Meier, Brooke Ashley, RN
11:01:59	Chief Complaint Filed		Meier, Brooke Ashley, RN
11:02	ED Nurse Notes	Dr. Sadzikowski at bedside to update patient and daughter. Patient shakes head no when asked if on blood thinners, history of ulcer, and recent surgery. Physician explaining and educating patient and daughter on use of TPA, daughter agrees to administration of TPA and patient shakes head yes.	Meier, Brooke Ashley, RN
11:03	Triage Completed		Meier, Brooke Ashley, RN
11:03	Acuity/Triage Complete	Acuity/Triage Complete - Acuity: ESI 2 ; Triage Complete: Triage complete	Meier, Brooke Ashley, RN
11:03:35	PATIENT ACUITY FILED		Meier, Brooke Ashley, RN
11:04	Phys Abuse Asm	Abuse Assessment - Have you ever been verbally, emotionally, financially, sexually, or physically harmed by your partner or anyone else?: Pt unable to communicate ; Do you feel safe in your home/environment?: Pt unable to communicate	Meier, Brooke Ashley, RN
11:04	Tuberculosis Screening	Tuberculosis Screening - Tuberculosis Exposure: No ; Positive Skin Test: No ; Cough: No ; Hemoptysis: No ; Weight Loss: No ; Night Sweats: No	Meier, Brooke Ashley, RN
11:05:02	Imaging Started	PORTABLE 1 VIEW CHEST	Crisher, Claire S
11:05:15	Imaging Resulted	(Final result) CT STROKE PROTOCOL HEAD/BRAIN W/O IV CONTRAST	Interface, Radiology
11:06:58	Imaging Ended	PORTABLE 1 VIEW CHEST	Crisher, Claire S
11:08	Vitals ED	Height and Weight - Weight: 45.36 kg (100 lb) (patient shakes head to weighing 100 lbs, daughter agrees)	Meier, Brooke Ashley, RN
11:08	Anthropometrics	Anthropometrics - Weight Change: 0	Meier, Brooke Ashley, RN
11:08	Custom Formula Data	Height and Weight - Percent Weight Change Since Birth: 0	Meier, Brooke Ashley, RN
11:09:44	ED Nurse Notes	Other flowsheet entries - Age: 82.19 ; Percent Weight Change Since Birth: 0 Contacted pharmacy for administration of TPA.	Meier, Brooke Ashley, RN
11:11:02	Orders Placed	PHYSICIAN TO NURSE	Sadzikowski, Mark R, MD
11:12:28	Orders Placed	STROKE RELATED ORDER SET WAS USED FOR THIS PATIENT ; HARDWIRE MONITOR ; NPO DIET ; VITAL SIGNS ; ASPIRATION PRECAUTIONS ; BLEEDING PRECAUTIONS ; CALL DOCTOR ; NEUROLOGICAL ASSESSMENT	Sadzikowski, Mark R, MD
11:12:29	Orders Placed	PHYSICIAN TO NURSE - Elevate Head of bed 30-45 degrees ; PHYSICIAN TO NURSE - NO foley insertion or Procedures for 24 hours after TPA administration ; PHYSICIAN TO SECRETARY - Notify stroke coordinator of patient admission ; Peripheral IV - Insert 18 gauge bilaterally to AC ; IV Anti-hypertensive Management ; NIHSS DOCUMENTATION ; PHQ-2 STROKE DEPRESSION SCREENING ; TEACH STROKE EDUCATION ; PHYSICIAN TO NURSE - Swallow Screening ; OXYGEN PER PROTOCOL ; alteplase (ACTIVASE) BOLUS HIGH ALERT 4 mg ; alteplase (ACTIVASE) 37 mg in 37 mL infusion HIGH ALERT ; sodium chloride 0.9 % infusion - post alteplase 50 mL ; ibuprofen (TRANDATE) injection 10-20 mg ; niCARdipine (CARDENE) 75 mg in sodium chloride 0.9 % 150 mL infusion ; sodium chloride infusion 0.9 %	Sadzikowski, Mark R, MD
11:12:31	Orders Completed	STROKE RELATED ORDER SET WAS USED FOR THIS PATIENT	Tuuri, Nancy J, PHARMACIST
11:15	Troponin Completed	TROPONIN I	McKlinsky, Ann, ED Tech
11:15	Vitals ED	Vital Signs - BP: 146/73 mmHg (Device Time: 11:15:00) ; MAP: 92 (Device Time: 11:15:00) ; Heart Rate : 51 (Device Time: 11:15:00) ; Resp: 16 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula	Meier, Brooke Ashley, RN
11:15	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 97 ; Shock Index (Read only): 0.3	Meier, Brooke Ashley, RN
11:16:15	PORTABLE 1 VIEW CHEST Resulted	No components filed Collected: 5/21/2017 11:15 Last updated: 5/21/2017 11:21 Status: Final result	Interface, Radiology
11:21:18	Imaging Resulted	(Final result) PORTABLE 1 VIEW CHEST	Interface, Radiology
11:22:29	ED Nurse Notes	Patient and daughter signed consent form for administration of TPA. Patient normally right handed per daughter but able to sign form with left hand, knowledgeable to date and able to write.	Meier, Brooke Ashley, RN

11:24:31	ED Nurse Notes Addendum	Pharmacist at bedside to deliver TPA to RN. Head of bed elevated to 45 degrees. Monitor maintained.	Meier, Brooke Ashley, RN
11:32	Medication Bolus From Bag/Syringe	alteplase (ACTIVASE) BOLUS HIGH ALERT 4 mg - Dose: 4 mg ; Rate: 240 mL/hr ; Route: Intravenous ; Scheduled Time: 1130 ; Comment: verified with Beverly RN	Meier, Brooke Ashley, RN
11:33	Peripheral IV 05/21/17 Left Forearm Placed	Removal Date/Time: 05/23/17 1317 Placement Date/Time: 05/21/17 1133 Inserted By: In ED;Tech Size (gauge): 18 Orientation: Left Location: Forearm Removed By: NA Post Removal Assessment: No complications;Catheter intact	McKlinsky, Ann, ED Tech
11:33	Peripheral IV 05/21/17 Left Forearm Assessment	Site Assessment: Clean, dry and intact ; Dressing: Clean dry & intact; Transparent dressing intact ; Line Status: Blood returned; Flushed	McKlinsky, Ann, ED Tech
11:33	Peripheral IV 05/21/17 Right Antecubital Assessment	Site Assessment: Clean, dry and intact ; Dressing: Clean dry & intact; Transparent dressing intact ; Line Status: Blood returned; Flushed	McKlinsky, Ann, ED Tech
11:34	Peripheral IV 05/21/17 Right Antecubital Placed	Removal Date/Time: 05/23/17 1318 Placement Date/Time: 05/21/17 1134 Inserted By: In ED;Tech Size (gauge): 18 Orientation: Right Location: Antecubital Removed By: NA Post Removal Assessment: No complications;Catheter intact	McKlinsky, Ann, ED Tech
11:34	Labs	Labs - Collected and Sent: Serum	McKlinsky, Ann, ED Tech
11:34	Peripheral IV 05/21/17 Right Antecubital Assessment	Site Assessment: Clean, dry and intact ; Dressing: Clean dry & intact; Transparent dressing intact ; Line Status: Blood returned; Flushed	McKlinsky, Ann, ED Tech
11:37	Medication New Bag	alteplase (ACTIVASE) 37 mg in 37 mL infusion HIGH ALERT - Dose: 37 mg ; Rate: 37 mL/hr ; Route: Intravenous ; Line: Peripheral IV 05/21/17 Left Forearm ; Scheduled Time: 1130 ; Comment: verified with Beverly RN	Meier, Brooke Ashley, RN
11:38	COMPLETE BLOOD COUNT W DIFF Resulted	WBC: 5.9 [Range: 3.3 - 10.7 bil/L] RBC: 4.34 [Range: 3.87 - 5.08 tril/L] Hemoglobin: 13.1 [Range: 12.1 - 15.0 g/dL] Hematocrit: 38.7 [Range: 35.4 - 44.2 %] MCV: 89 [Range: 80 - 100 fL] MCH: 30 [Range: 28 - 33 pg] MCHC: 34 [Range: 32 - 35 g/dL] RDW SD: 45 [Range: 40 - 50 fL] RDW CV: 14 [Range: 12 - 15 %] Platelets: 256 [Range: 150 - 400 bil/L] Neutrophils: 4.1 [Range: 1.6 - 7.2 bil/L] Lymphocytes: 1.1 [Range: 1.1 - 4.0 bil/L] Monocytes: 0.5 [Range: 0.0 - 0.8 bil/L] Eosinophils: 0.1 [Range: 0.0 - 0.5 bil/L] Basophils: 0.0 [Range: 0.0 - 0.1 bil/L] Immature Granulocytes: 0.01 [Range: 0.00 - 0.03 bil/L] Collected: 5/21/2017 11:15 Last updated: 5/21/2017 11:38 Status: Final result	Interface, Lab
11:47	ED Nurse Notes Addendum	First 15 min neuro check performed. Patients speech slightly less slurred, daughter stated sounds more normal for patient but patient is still speaking slower. Patients grip strength on right hand and arm a little stronger than prior to medication administration but still not equally strong as left arm.	Meier, Brooke Ashley, RN
11:47	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Delayed response(s); Slurred speech ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 4 (active movement against gravity and some resistance – cannot resist examiner) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right	Meier, Brooke Ashley, RN
11:47	Vitals ED	Vital Signs - BP: 138/62 mmHg ; Heart Rate: 45 (Device Time: 11:47:00) ; Resp: 16 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula Pain Scale / Interventions - Pain Score: 0	Meier, Brooke Ashley, RN
11:47	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 87 ; Shock Index (Read only): 0.3	Meier, Brooke Ashley, RN
11:55	Pre Admit Alert	Pre Admit Alert - Is this patient a potential admission: Yes	Sadzikowski, Mark R, MD
11:57	PROTIME AND APTT Resulted	Prolime: 9.9 [Range: 9.3 - 12.4 seconds] INR: 0.9 (2.0 to 3.0 Routine Oral Anticoagulant Therapy 2.5 to 3.5 Oral Anticoagulant Therapy for Mechanical Heart Valves: For more detailed information, see Beaumont Pharmacy website.) aPTT: 28.0 (Heparin Therapeutic Range: 52-77 seconds is comparable to 0.3-0.7 U/mL of heparin.) [Range: 23.0 - 30.0 seconds] Collected: 5/21/2017 11:15 Last updated: 5/21/2017 11:57 Status: Final result	Interface, Lab
11:57	COMPREHENSIVE METABOLIC PANEL (CMP) Resulted	Abnormal Result Sodium: 138 [Range: 135 - 145 mmol/L] Potassium: 3.6 [Range: 3.5 - 5.2 mmol/L] Chloride: 101 [Range: 98 - 110 mmol/L] Carbon Dioxide (CO2): 32 [Range: 22 - 32 mmol/L] Anion Gap: 5 [Range: 5 - 17] Glucose: 107 (Fasting glucose: 60-99 mg/dL Random glucose: 60-139 mg/dL) [Range: 60 - 99 mg/dL] Blood Urea Nitrogen (BUN): 24 [Range: 8 - 22 mg/dL] Creatinine: 0.76 [Range: 0.60 - 1.40 mg/dL] GFR Non African American: 73 [Range: >59 mL/min/1.73m2]	Interface, Lab

GFR African American: 85 (Glomerular Filtration Rate is estimated from serum creatinine, age, gender, and race using the CKD-EPI equation. GFR categories in CKD are for both African American and Non-African American:

G1: Normal GFR: >=90
 G2: Mildly decreased GFR: 60-89
 G3a: Mildly to moderately decreased GFR: 45-59
 G3b: Moderately to severely decreased GFR: 30-44
 G4: Severely decreased GFR: 15-29
 G5: Kidney failure GFR: <15
) [Range: >59 mL/min/1.73m²]
 Calcium: 8.8 [Range: 8.4 - 10.4 mg/dL]
 Protein Total: 6.3 [Range: 6.4 - 8.3 g/dL]
 Albumin: 3.1 [Range: 3.5 - 4.9 g/dL]
 Globulin: 3.2 [Range: 2.2 - 3.7 g/dL]
 Albumin/Globulin Ratio: 1.0
 Alkaline Phosphatase (ALP): 88 [Range: 34 - 125 U/L]
 Aspartate Aminotransferase (AST): 28 [Range: 10 - 37 U/L]
 Alanine Aminotransferase (ALT): 36 [Range: 20 - 65 U/L]
 Bilirubin Total: 0.3 [Range: 0.3 - 1.2 mg/dL]
 Collected: 5/21/2017 11:15
 Last updated: 5/21/2017 11:57
 Status: Final result

11:57	TROPONIN I Resulted	<p>Troponin I: <0.03 (<=0.05 Normal 0.06-0.19 Indeterminate for myocardial damage >=0.20 Indicates or highly suggestive of myocardial damage</p> <p>Troponin I is elevated in acute coronary syndromes with myocardial necrosis as well as ST elevation MI. Increases are also associated with direct myocardial damage (myocarditis, pericarditis, contusion, cardioversion), myocardial strain (CHF, pulmonary hypertension, pulmonary embolus) and demand ischemia (sepsis, hypotension, atrial fibrillation). Troponin may also be elevated with renal failure, intracranial hemorrhage and amyloidosis. The mechanism for the latter elevations is unclear. An elevated troponin level is a predictor for poor outcomes regardless of its cause.</p> <p>Ann Intern Med 2005;142:786-791.) [Range: 0.00 - 0.05 ng/mL] Collected: 5/21/2017 11:15 Last updated: 5/21/2017 11:57 Status: Final result</p>	Interface, Lab
12:02	ED Nurse Notes	2nd 15 minute neuro check performed. Patient grip strengths equally strong bilaterally. Daughter stated patient still speaking slightly slower but than normal with slurred speech resolved, patient has accent. Neurologist at bedside, patient asking questions at this time, "what is my blood pressure", "did this happen because of my blood pressure". A&Ox3. Patients and family questions answered by Neurologist.	Meier, Brooke Ashley, RN
12:02	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear (patient has accent) ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right	Meier, Brooke Ashley, RN
12:02	Vitals ED	Vital Signs - BP: 150/72 mmHg ; Heart Rate : 48 (Device Time: 12:02:00) ; Resp: 16 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula	Meier, Brooke Ashley, RN
12:02	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 98 ; Shock Index (Read only): 0.3	Meier, Brooke Ashley, RN
12:02:22	Orders Acknowledged	New - PHYSICIAN TO NURSE - Elevate Head of bed 30-45 degrees	Meier, Brooke Ashley, RN
12:02:32	Orders Acknowledged	New - PHYSICIAN TO NURSE - NO foley insertion or Procedures for 24 hours after TPA administration	Meier, Brooke Ashley, RN
12:02:33	Orders Acknowledged	New - PHYSICIAN TO SECRETARY - Notify stroke coordinator of patient admission	Meier, Brooke Ashley, RN
12:02:34	Orders Acknowledged	New - Peripheral IV - insert 18 gauge bilaterally to AC	Meier, Brooke Ashley, RN
12:02:35	Orders Acknowledged	New - IV Anti-hypertensive Management	Meier, Brooke Ashley, RN
12:02:40	Orders Acknowledged	New - NIHSS DOCUMENTATION	Meier, Brooke Ashley, RN
12:09	Travel Screening	TRAVEL SCREENING - Have you traveled outside the USA or has family or friends you live with traveled outside the USA in the past 21 days (3 weeks)?: No	Martin, Donna M, RN
12:10	Assign Attending	ALMASRI, B assigned as Attending Provider	Sadzikowski, Mark R, MD
12:10:18	Admit Disposition Selected	ED Disposition set to Admission	Sadzikowski, Mark R, MD
12:10:18	Orders Placed	CONSULT TO PHYSICIAN ; Admit Patient ; TMS MONITOR	Sadzikowski, Mark R, MD
12:10:19	Assign EC Physician		Martin, Donna M, RN
12:12	Admit Data	Collection/Transport - Draw Status: Lab Collect ; Transport Mode: Stretcher Admit Data - Valuables Disposition: Kept with Patient ; Medications Disposition: None ; Unit Orientation: Patient Information Handbook provided.; Pt oriented to bed operation, bed rail safety, bed rail use for mobility, nurse call light, computer, meal service, pt/visitor bathroom, smoking regulations, telephone/TV and visitor regulations Height and Weight - Height: 162.6 cm (5' 4") ; Height Source: Pt estimate ; Weight: 45.36 kg (100 lb) ; Weight Source: Pt estimate ; BSA: 1.43 sq meters Dosing Weight - Dosing Weight: 45.36 kg (100 lb) MRI Screening - Metal and/or Devices Implanted or Adhered to Body: No Cultural/Spiritual/End of Life Needs - Identified Cultural/Spiritual/End of Life Needs: None identified	Martin, Donna M, RN
12:12	Anthropometrics	Anthropometrics - Weight Change: 0	

12:12	Custom Formula Data	<p>Height and Weight - BMI: 17.2</p> <p>Height and Weight - Percent Weight Change Since Birth: 0</p> <p>Other flowsheet entries - IBWlb (Calculated) FEMALE: 120 ; IBWlb (Calculated) MALE: 130 ; Protein Goal - Optimal (female): 82 gm ; Protein Goal - Standard (female): 65 gm ; Current excess weight (female): -20 ; Protein Goal - Optimal (male): 89 gm ; Proteing Goal - Standard (male): 71 gm ; Current excess weight (male): -30 ; Age: 82.19 ; BMI (Calculated): 17.2 ; BSA (Calculated - sq m): 1.43 sq meters ; IBW/kg (Calculated) Male: 59.2 kg ; Low Range Vt 6cc/kg MALE: 355.2 mL ; Adult Moderate Range Vt 8cc/kg MALE: 473.6 mL ; Adult High Range Vt 10cc/kg MALE: 592 mL ; IBW/kg (Calculated) FEMALE: 54.7 kg ; Low Range Vt 6cc/kg FEMALE: 328.2 mL ; Adult Moderate Range vt 8cc/kg FEMALE: 437.6 mL ; Adult High Range Vt 10cc/kg FEMALE: 592 mL ; Weight in (lb) to have BMI = 26: 145.3 ; Percent Weight Change Since Birth: 0</p>	Martin, Donna M, RN Martin, Donna M, RN
12:13	Morse Fall / CAM	<p>Morse Fall Risk w/CAM - History of Falling: Immediate or within 3 months: No ; Secondary Diagnosis: No ; Ambulatory Aids: None/bedrest/nurse assist ; Intravenous Therapy/Heparin/Saline Lock: Yes ; Gait/Transferring: Normal/bedrest/immobile ; Mental Status: Oriented to own ability ; Score: 20</p> <p>CAM - Mental State Change: No ; Inattention: No evidence of difficulty focusing, distractibility, inability to follow topic ; Disorganized Thinking: No evidence of rambling, irrelevant conversation, unpredictable subject switch ; Level of Consciousness: Alert</p>	Martin, Donna M, RN
12:13	Adm Vitals/ Pain	<p>Chronic Pain Assessment - Chronic Pain: No</p> <p>Acute Pain Assessment - Acute Pain: No</p> <p>Acute Pain Details - Pain Scale Type: Numeric pain scale</p> <p>Numeric Pain Scale - Pain Score: 0</p> <p>(POSS) Pasero Opioid-Induced Sedation Scale - (POSS) Pasero Opioid-Induced Sedation Scale: 1 – Awake and alert</p> <p>Pain Understanding & Goal - Pain Understanding: No needs due to no pain ; Pain Goal: 0 (no pain)</p>	Martin, Donna M, RN
12:13	Lay Caregiver	Designate Lay Caregiver - Does patient want to designate a lay caregiver?: Declined	Martin, Donna M, RN
12:13	Custom Formula Data	Fall Risk Assessment - Fall Risk Score: 0	Martin, Donna M, RN
12:14	Physical Asm	<p>Assessment - Assessment Type: Admission</p> <p>Neurological - Neurological: X (CVA prior to admission with resolving R side deficits)</p> <p>Glasgow Coma Scale - Glasgow Coma Scale: WNL</p> <p>HEENT - Eyes Bilateral: Glasses/Contacts required (not with her, per pt) ; HEENT: X</p> <p>Respiratory - Respiratory: X (100% on 2L NC)</p> <p>Cardiac - Cardiac Monitor: Yes ; Cardiac: X</p> <p>Gastrointestinal - Gastric Characteristics: No nausea or vomiting ; Last Bowel Movement: Within 24h ; Stool Characteristics: Soft, formed, brown ; Gastrointestinal: WNL</p> <p>Urine - Urine Control/Sensation: Voids without difficulty (continent)</p> <p>Skin - Skin: WNL (per pt)</p> <p>Mucous Membranes - Mucous Membranes: WNL</p> <p>Urinary Tract - Urinary Tract: WNL</p> <p>Musculoskeletal - Musculoskeletal: X (CVA prior to arrival, resolving R sided deficits)</p> <p>Peripheral Vascular - Peripheral Vascular: X (CVA prior to arrival; pt receiving TPA)</p> <p>Data Review & Verification - Data Review/Verified: Reviewed/Verified</p>	Martin, Donna M, RN
12:14	Risk Screening	<p>Nursing Swallow Screening - "Are there past or present signs or symptoms of stroke, TIA or neurological impairment?": Yes ; Is patient alert, cooperative, and able to follow simple commands?: Yes</p> <p>Nutrition Screen - Malnutrition Universal Screening Tool (MUST) - Any unplanned weight loss in the past 3 - 6 months?: No (0-10lbs) ; Last BMI: 17.2 ; BMI MUST Score: 2 ; Any significant decrease in appetite or intake in the past 3 - 6 months: No ; Nutrition Screening Score: 2</p> <p>Functional Screening - ADL Prior to Adm: Performed Independently ; Current Ambulation Level: Ambulates independently</p> <p>PT/OT/SLP Screening - Dx Exceptions: No diagnosis exceptions ; Therapy Screening: No referral recommended at this time</p> <p>Epidemiology Screening - Prior Residence: Residence was NOT an ECF, NH, LTACH or another hospital prior to the current adm ; Isolation Assessment Needs: Patient does not require Isolation</p> <p>Patient Prior Location - Last physical overnight location of patient immediately prior to arriving into facility.: Personal Residence/Residential Care ; Has patient been discharged from another facility in the past 4 weeks?: No</p> <p>Abuse Assessment - Have you ever been verbally, emotionally, financially, sexually, or physically harmed by your partner or anyone else?: No ; Do you feel safe in your home/environment?: Yes ; Patient has physical or behavioral indicators of abuse/neglect?: No</p> <p>Alcohol Screening - How often do you have a drink containing alcohol: 4 or more times a week ; How many standard drinks containing alcohol do you have on a typical day?: 1 or 2 ; How often do you have six or more drinks on one occasion: Never ; Alcohol Risk Total: 4</p> <p>Drug Abuse Screening - Drug Use Screening: No</p> <p>Suicide Assessment > 5 yrs - Subst Abuse/Emotional Problems: No ; Suicidal Thoughts: No</p> <p>PFV Risk Indicators - Primary Risk Indicators: No primary risk indicators ; Additional Risk Indicators: No primary or additional risk factors</p>	Martin, Donna M, RN
12:14	Bradon	Braden Scale - Sensory/Perceptual: No Impairment ; Moisture: Rarely Moist ; Activity: Walks frequently ; Mobility: No Impairment ; Nutrition: Adequate ; Friction & Shear: No problem ; Braden Calculation: 22	Martin, Donna M, RN
12:14	Custom Formula Data	Other flowsheet entries - AUDIT-C Score: 4 ; Risk Level: No Risk ; Audit-C Alcohol: 2	Martin, Donna M, RN
12:14	Peripheral IV 05/21/17 Left Forearm Assessment	Site Assessment: Clean, dry and intact ; Dressing: Transparent dressing intact ; Line Status: Infusing	Martin, Donna M, RN
12:14	Peripheral IV 05/21/17 Right Antecubital Assessment	Site Assessment: Clean, dry and intact ; Dressing: Transparent dressing intact ; Line Status: Clamped	Martin, Donna M, RN
12:15	Cognitive Functional	<p>Cognitive and Functional Status (If you answer 'Yes' to any of the below, a detailed assessment should be documented) - Difficultly with Hearing: No ; Difficulty with Sight: No ; Difficultly with Walking/Climbing Stairs: No ; Difficultly with Dressing/Bathing: No ; Difficultly with Errands: No ; Difficultly with Focus: No</p> <p>Cognitive and Functional Status (If you answer 'Yes' to any of the below, a detailed assessment should be documented) - Difficultly with Hearing: No ; Difficulty with Sight: No ; Difficultly with Walking/Climbing Stairs: No ; Difficultly with Dressing/Bathing: No ; Difficultly with Focus: No</p> <p>Cognitive and Functional Status (If you answer 'Yes' to any of the below, a detailed assessment should be documented) - Difficultly with Hearing: No ; Difficultly with Sight: No</p>	Martin, Donna M, RN
12:15:55	Orders Acknowledged	New - CONSULT TO PHYSICIAN	Meier, Brooke Ashley, RN
12:15:58	Orders Acknowledged	New - Admit Patient ; TMS MONITOR	Meier, Brooke Ashley, RN

12:16:09	Orders Modified	CONSULT TO PHYSICIAN (Comment: Modified from CONSULT TO PHYSICIAN)	Sadzikowski, Mark R, MD Plummer, Kamille
12:16:09	Orders Discontinued	CONSULT TO PHYSICIAN	Plummer, Kamille
12:16:09	Consult Orders Discontinued	CONSULT TO PHYSICIAN	Meier, Brooke Ashley, RN
12:17	ED Nurse Notes Addendum	3rd 15 minute neuro check performed. Grips and arm strength equal bilaterally. Daughter still stated speech slower than normal but denies patient having slurred speech. Slight decrease in right sided mouth droop. Patient denies headache and dizziness.	Meier, Brooke Ashley, RN
12:17	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear; Delayed response(s) ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal)	Meier, Brooke Ashley, RN
12:17	Vitals ED	Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right Vital Signs - BP: 142/63 mmHg ; Heart Rate : 46 (Device Time: 12:17:00) ; Resp: 16 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula; Non-rebreather mask Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Verbal Response: Oriented ; Best Motor Response: Obey verbal command ; Glasgow Coma Scale Score: 15 Pain Scale / Interventions - Pain Score: 0	Meier, Brooke Ashley, RN
12:17	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 89 ; Shock Index (Read only): 0.3	Meier, Brooke Ashley, RN
12:20	Medication Stopped	alteplase (ACTIVASE) 37 mg in 37 mL infusion HIGH ALERT - Route: Peripheral IV 05/21/17 Left Forearm ; Scheduled Time: 1237	Meier, Brooke Ashley, RN
12:21	Medication Given	sodium chloride 0.9 % infusion - post alteplase 50 mL - Dose: 50 mL ; Route: Intravenous ; Line: Peripheral IV 05/21/17 Left Forearm ; Scheduled Time: 1130 ; Comment: Stopped @ 1246	Meier, Brooke Ashley, RN
12:21:11	ED Nurse Notes	Admission complete	Marlin, Donna M, RN
12:24	ED Nurse Notes	Small swollen area noted to left AC where IV hełock was attempted by tech when patient arrived, no bleeding noted, Dr. Sadzikowski notified, stated to apply ice. Ice pack applied. Patient denies pain to area, no warmth noted.	Meier, Brooke Ashley, RN
12:26:46	IP Bed Requested		Romeo, Jennifer A
12:32	ED Nurse Notes	4th 15 minute neuro check performed. Grips and arm strength equal bilaterally. Daughter still stated speech slower than normal but denies patient having slurred speech. Slight decrease in right sided mouth droop. Patient denies headache and dizziness.	Meier, Brooke Ashley, RN
12:32	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear; Delayed response(s) ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal)	Meier, Brooke Ashley, RN
12:32	Vitals ED	Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right Vital Signs - BP: 136/64 mmHg ; Heart Rate : 74 (Device Time: 12:32:00) ; Resp: 18 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Verbal Response: Oriented ; Best Motor Response: Obey verbal command ; Glasgow Coma Scale Score: 15 Pain Scale / Interventions - Pain Score: 0	Meier, Brooke Ashley, RN
12:32	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 88 ; Shock Index (Read only): 0.5	Meier, Brooke Ashley, RN
12:40	THYROID STIMULATING HORMONE (TSH) Resulted	Abnormal Result TSH: 6.49 (Pregnancy Ranges: 1st trimester 0.26 - 2.66 2nd trimester 0.55 - 2.73 3rd trimester 0.43 - 2.91) [Range: 0.40 - 4.50 mclU/mL] Collected: 5/21/2017 11:15 Last updated: 5/21/2017 12:40 Status: Final result	Interface, Lab
12:41	Swallow Screening	Nursing Swallow Screening - "Are there past or present signs or symptoms of stroke, TIA or neurological impairment?": Yes ; Is patient alert, cooperative, and able to follow simple commands?: Yes ; Adult nursing swallow screen for the administration of oral medication: Passed	Meier, Brooke Ashley, RN
12:47	ED Nurse Notes	5th 15 minute neuro check performed. Grips and arm strength equal bilaterally. Daughter still stated speech slower than normal but denies patient having slurred speech. Slight decrease in right sided mouth droop. Patient denies headache and dizziness. Transporter at bedside, will transport patient to room via stretcher.	Meier, Brooke Ashley, RN
12:47	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear; Delayed response(s) ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue – normal)	Meier, Brooke Ashley, RN
12:47	Vitals ED	Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right Vital Signs - BP: 128/58 mmHg ; Heart Rate : 47 (Device Time: 12:47:00) ; Resp: 14 ; Temp: 97.3 °F (36.3 °C) ; Temp Source: Oral ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Verbal Response: Oriented ; Best Motor Response: Obey verbal command ; Glasgow Coma Scale Score: 15 Pain Scale / Interventions - Pain Score: 0	Meier, Brooke Ashley, RN

12:47	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 81 ; Shock Index (Read only): 0.4 Relevant Labs and Vitals - Temp (in Celsius): 36.3	Meier, Brooke Ashley, RN
12:47:34	ED Nurse Notes	Swollen area that was noted previously to left AC where IV heplock was attempted by tech when patient arrived has increased to the size of a golf ball, no bleeding noted, Dr. Abukasm notified, stated to monitor and no additional interventions at this time. Patient denies pain to area, no warmth noted.	Meier, Brooke Ashley, RN
13:00	Admit Data	Collection/Transport - Draw Status: Lab Collect ; Transport Mode: Stretcher Admit Data - Valuables Disposition: Kept with Patient ; Medications Disposition: None ; Unit Orientation: Patient Information Handbook provided.; Pt oriented to bed operation, bed rail safety, bed rail use for mobility, nurse call light, computer, meal service, pt/visitor bathroom, smoking regulations, telephone/TV and visitor regulations Height and Weight - Height: 162.6 cm (5' 4.02") ; Height Source: Pt estimate ; Weight: 47.6 kg (104 lb 15 oz) ; Weight Source: Pt estimate ; BSA: 1.47 sq meters Dosing Weight - Dosing Weight: 47.6 kg (104 lb 15 oz) MRI Screening - Metal and/or Devices Implanted or Adhered to Body: No Cultural/Spiritual/End of Life Needs - Identified Cultural/Spiritual/End of Life Needs: None identified	Smolenski, Stefan, RN
13:00	NIHSS	Initial Last Known Well Documentation For Stroke (For Provider and MLP documentation only) - Date Last Known Well: 05/21/17 ; Is Last Known Well Date AND Time Known: Yes Assessment - Assessment Type: Admission Assessment NIHSS - Level of Consciousness: Alert; keenly responsive ; LOC Questions: Answers both questions correctly ; LOC Commands: Performs both tasks correctly ; Best Gaze: Normal ; Visual: No visual loss ; Facial Palsy: Minor paralysis (flattened nasolabial fold, asymmetric on smiling) ; Motor Left Arm: No drift, limb holds 90 (or 45) degrees for full 10 seconds ; Motor Right Arm Drift, limb holds 90 (or 45) degrees but drifts down before full 10 seconds; does not hit bed ; Motor Left Leg: No drift, leg holds 30 degrees for full 5 seconds ; Motor Right Leg: No drift, leg holds 30 degrees for full 5 seconds ; Limb Ataxia: Absent ; Sensory: Normal, no sensory loss ; Best Language: Mild to moderate aphasia, some obvious loss of fluency or facility of comprehension without significant limitation on ideas expressed or form of expression. ; Dysarthria: Normal ; Extinction and Inattention: No abnormality ; NIHSS Score: 3	Smolenski, Stefan, RN
13:00	Anthropometrics	Anthropometrics - Weight Change: 4.94	Smolenski, Stefan, RN
13:00	Custom Formula Data	Height and Weight - BMI: 18 Height and Weight - Percent Weight Change Since Birth: 0 Other flowsheet entries - IBW/lb (Calculated) FEMALE: 120.08 ; IBW/lb (Calculated) MALE: 130.1 ; Protein Goal - Optimal (female): 82 gm ; Protein Goal - Standard (female): 65 gm ; Current excess weight (female): -15.14 ; Protein Goal - Optimal (male): 89 gm ; Protein Goal - Standard (male): 71 gm ; Current excess weight (male): -25.16 ; Age: 82.19 ; BMI (Calculated): 18 ; BSA (Calculated - sq m): 1.47 sq meters ; IBW/kg (Calculated) Male: 59.24 kg ; Low Range VI 6cc/kg MALE: 355.44 mL ; Adult Moderate Range VI 8cc/kg MALE: 473.92 mL ; Adult High Range VI 10cc/kg MALE: 592.4 mL ; IBW/kg (Calculated) FEMALE: 54.74 kg ; Low Range VI 6cc/kg FEMALE: 328.44 mL ; Adult Moderate Range VI 8cc/kg FEMALE: 437.92 mL ; Adult High Range VI 10cc/kg FEMALE: 592.4 mL ; Weight in (lb) to have BMI = 25: 145.4 ; Percent Weight Change Since Birth: 0	Smolenski, Stefan, RN
13:02	ED Nurse Notes	6th 15 minute neuro check performed. Grips and arm strength equal bilaterally. Daughter still stated speech slower than normal but denies patient having slurred speech. Slight decrease in right sided mouth droop. Patient denies headache and dizziness. Patient in transport at this time, writer at bedside, monitor maintained.	Meier, Brooke Ashley, RN
13:02	Neurological	Neurological - Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear; Delayed response(s) ; Bilateral Pupils: 4-5 ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue - normal)	Meier, Brooke Ashley, RN
13:02	Vitals ED	Neurological - Memory: No memory deficit ; Facial Droop: Mouth, right Vital Signs - BP: 132/64 mmHg ; Heart Rate : 49 ; Resp: 16 ; SpO2: 100 % ; O2 (L/min): 2 ; Method of O2 Delivery: Nasal cannula Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Verbal Response: Oriented ; Best Motor Response: Obey verbal command ; Glasgow Coma Scale Score: 15 Pain Scale / Interventions - Pain Score: 0	Meier, Brooke Ashley, RN
13:02	Custom Formula Data	Sepsis Screen - Calculated MAP (Read only): 87 ; Shock Index (Read only): 0.4	Meier, Brooke Ashley, RN
13:15	Patient admitted	To department 2 CRITICAL CARE UNIT GP	Smith, Zandra R
13:15	Physical Asm	Neurological - Memory: No memory deficit ; Neurological: X Glasgow Coma Scale - Glasgow Coma Scale: WNL HEENT - HEENT: X	Smolenski, Stefan, RN
13:15	ICU Neurology	Glasgow Coma Scale - Eyes Open: Opens eyes spontaneously ; Best Verbal Response: Oriented ; Best Motor Response: Obey verbal command ; Glasgow Coma Scale Score: 15 Neuro - Facial Droop: Mouth, right ; Level of Consciousness: Alert ; Orientation: Oriented x3 (person, place, time) ; Cognition: Able to follow complex, multiple step commands ; Speech/Language: Speech clear; Delayed response(s) ; RASS: Alert and calm ; Bilateral Pupils: 4-5 Neuro - Reflexes - Corneal Reflex Bilateral: Present ; Cough Reflex: Present ; Neuromuscular Response LUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response RUE: Spontaneous and purposeful; Grips; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response LLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue - normal) ; Neuromuscular Response RLE: Spontaneous and purposeful; Strong; 5 (active movement against full resistance without evident fatigue - normal)	Smolenski, Stefan, RN
13:15:50	Charting Complete		Sadzikowski, Mark R, MD
13:15:50	Charting Complete		Korpala, Ryan

ADT Events

Date/Time	Event	Pt Class	Unit	Room/Bed
05/21/17 1035	Patient arrived in ED		EMERGENCY CENTER GP	
05/21/17 1036	Patient roomed in ED	Emergency Patient	EMERGENCY CENTER GP	0102A/0102A
05/21/17 1210	Patient Update	Inpatient	EMERGENCY CENTER GP	0102A/0102A
05/21/17 1315	Dispo	Inpatient	2 CRITICAL CARE UNIT GP	0001A/0001A
05/22/17 2324	Transfer Out	Inpatient	2 CRITICAL CARE UNIT GP	0001A/0001A

05/22/17 2324	Transfer In	Inpatient	2 CRITICAL CARE STEP DOWN GP	0236A/B/0236B
05/23/17 1439	Discharge	Inpatient	2 CRITICAL CARE STEP DOWN GP	0236A/B/0236B

Meier, Brooke Ashley, RN	Registered Nurse	Addendum	Emergency Medicine	ED Nurse Notes	05/21/17 1040
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Patient presents via EMS from home. Patient able to answer questions by shaking head yes or no but is unable to speak at this time. Mumbled noises noted when patient attempts to verbally answer questions. Daughter at bedside stated mother normally A&Ox3, performs ADL's self. Daughter stated at about 1010 today, mother began to shake right arm, became confused, and was unable to speak so daughter called EMS. Right sided weakness to right arm and right sided facial droop noted. Patient placed on monitor, continuous pulse ox, and BP. Code Stroke initiated prior to patients arrival. Patient shakes head no to headache, dizziness, SOB, and pain. Dr. Sadzikowski at bedside.

Revision History



Meier, Brooke Ashley, RN	Registered Nurse	Signed	Emergency Medicine	ED Nurse Notes	05/21/17 1122
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Patient and daughter signed consent form for administration of TPA. Patient normally right handed per daughter but able to sign form with left hand, knowledgeable to date and able to write.

Meier, Brooke Ashley, RN	Registered Nurse	Addendum	Emergency Medicine	ED Nurse Notes	05/21/17 1147
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First 15 min neuro check performed. Patients speech slightly less slurred, daughter stated sounds more normal for patient but patient is still speaking slower. Patients grip strength on right hand and arm a little stronger than prior to medication administration but still not equally strong as left arm.

Revision History

