

**Do you have three separate order sets for regular admits and three different ones for ICU admits? (ischemic, hemorrhagic, and SAH)OR, do you just have three sets period (regardless of where the patient may end up).**

We have separate orders sets for ischemic, hemorrhagic and TIA on the floor, and then ischemic ICU and hemorrhagic ICU. We just merged ICU admission order set with the ischemic and hemorrhage and adjusted the ICU admission order set to meet the need of the ischemic and hemorrhagic patients.

We have one order set for the ED to follow, one order set for t-PA use, one order set for inpatient admissions (all attached below)

We do not have separate order sets for ICU level of care. We use the following order sets:

- Ischemic Stroke/TIA Admission Orders
- t-PA (Tissue Plasminogen Activator) Administration for Ischemic Stroke
- Stroke Post t-PA Admission Orders (Captures all the items in the first one listed, but with tPA precautions like BP parameters, no noncompressible sticks, and leaves off ASA x 24 hours)
- Intracerebral Hemorrhage Admission Orders

We have 3 separate preprinted order sets for Brain Attack/Tia, Intracerebral hemorrhage and SAH. These are used regardless of the admission location of the patient.

We have separate order sets for ischemic, intracerebral and SAH. We are re-doing our order sets to include an admission order set for all neuro patients which will be paired with the stroke type specific order set. Goal is two pages tops - parts of our system are still living in the paper world. The order set goes with the patient and is not dictated by which unit they will be admitted to.

We do not have separate orders for ICU or general admits.

We have both ICU and non-ICU admission order sets for ICH, one order set for stroke/TIA admission for non-IV tPA patients and another for patients who receive tPA and one order set for SAH. We also have separate ED order sets for ICH, SAH, Stroke, Stroke with IV tPA and TIA.

We have TIA and ischemic under one order set, Hem. And SAH under a separate order set.

**2. Do your ED physicians also complete the admission order sets? If not, who completes them...ie, residents, PCP's Etc.**

Neurologist are always called for all strokes - so they begin order sets.

At our facility, the ED physicians do not have admitting privileges, therefore, the admitting physician must fil out the admit order set.

Our residents, APN's and neurology/neurosurgical physicians complete the preprinted orders on admission. Our ED physicians do not complete these orders. They consult the appropriate service and that service then completes the orders.

Our order sets are primarily used by the neurologists (never by the ED physicians). We do have some hospitalists who use them, and we are encouraging the neurosurgeons to use the ICH order set, but old habits die hard!

We have a separate, abbreviated order set for the ED MD which gets the admission process started but the more specific stroke orders are completed by the PCP or the neurologist.

No. The admitting MD completes the order sets and not all practices uses the order sets. They are always used by the Neurology service. Our order sets are now computerized and this has helped somewhat.

The admitting physician does the order set (never the ED). For non-tPA ischemic, it is usually the hospitalist/resident, for tPA, it is the neurologist, for SAH and ICH it is usually an intensivist, neurosurgeon or neurointerventionalist.

No, our ED physicians do not fill out order sets. PCP or hospitalist or whoever is admitting.

**3. During an inpatient code stroke...who obtains the "informed consent" for t-PA...does your neurologists come in at night, or do they just do a phone consent?**

During our inpatient stroke alert the stroke neurologist and residents respond to the alert. At night we have an in house resident who responds and notifies the stroke attending on call who then comes in for thrombolytic/interventional treatment. We explain the risk and benefits of tpa and do not get informed consent as it is considered a standard treatment. If are deviating from the relative contraindications we will have them sign a consent once all the risk and benefits have been explained. For interventional treatment we will get signed consent .

same as #2 above

The consent would be obtained by the neurologist, if they are the attending. Generally, a patient who has a stroke during a hospital stay has a non-neurology attending physician who would be responsible for gaining informed consent for t-PA use.

We do not get written informed consent for tPA since this is standard of care and permits are not required. Our neurologists discuss risk and benefits with the patient/family, and give tPA with verbal consent only which they document in their H&P.

An informed consent is not needed for IV tPA. It is the standard of care. Somebody has to discuss/document the risks associated with administration as we would for other procedures etc. but the informed consent has gone by the wayside. I just heard a talk yesterday where the speaker stated that there is a growing number of lawsuits in which tPA was not offered as a treatment for ischemic stroke.

We do not get informed consent for tPA. Our on call Neurologist on call will come in for a code stroke 24/7.

We do not obtain informed consent for tPA as it is a standard of care but the neurologist always comes in and does an in-person assessment and discusses the treatment options with the patient/family before IV tPA is given.

AHA Guidelines on Early Management of Adults with ischemic stroke on page 1676 says you don't have to have informed consent.

We have 24/7 neuro on call. We have phone contact with them.