



Wimmera
Health Care
Group

ID Label

STROKE / T.I.A. CLINICAL PATHWAY

Issued June 2000 - Revised July 2008 (version 6)

**The Pathway is for acute management over seven days
(state average L.O.S.)**

It is not intended for the rehabilitation phase of care.

Planned Length of Stay for T.I.A./ minor stroke: Three Days

Information/ Instructions for Use:

- This Clinical Pathway is intended as a guide only and does not replace clinical judgment.
- This is a multidisciplinary pathway developed using evidence of current best practice. Each discipline initials after the intervention is completed. The signature register is to be completed once only by all staff who provide care to allow identification of initialisation.
- The pathway includes a Stroke Algorithm and medical plan with criteria for investigations and management, education and discharge plan and patient assessment forms for all disciplines.
- If tasks are not applicable to the patient, document with X. If outcomes are not achieved a variance is marked with a circled black 'V' and recorded in the progress notes, i.e. Please maintain chronological order. (V)
- A Generic post stroke form may be used beyond Day 6 if patient remains acutely ill.
Do not use Discharge day until actual expected discharge day.

KEY:

Initial

X

Black (V)

if attended (ensure signature register is completed)

if not applicable

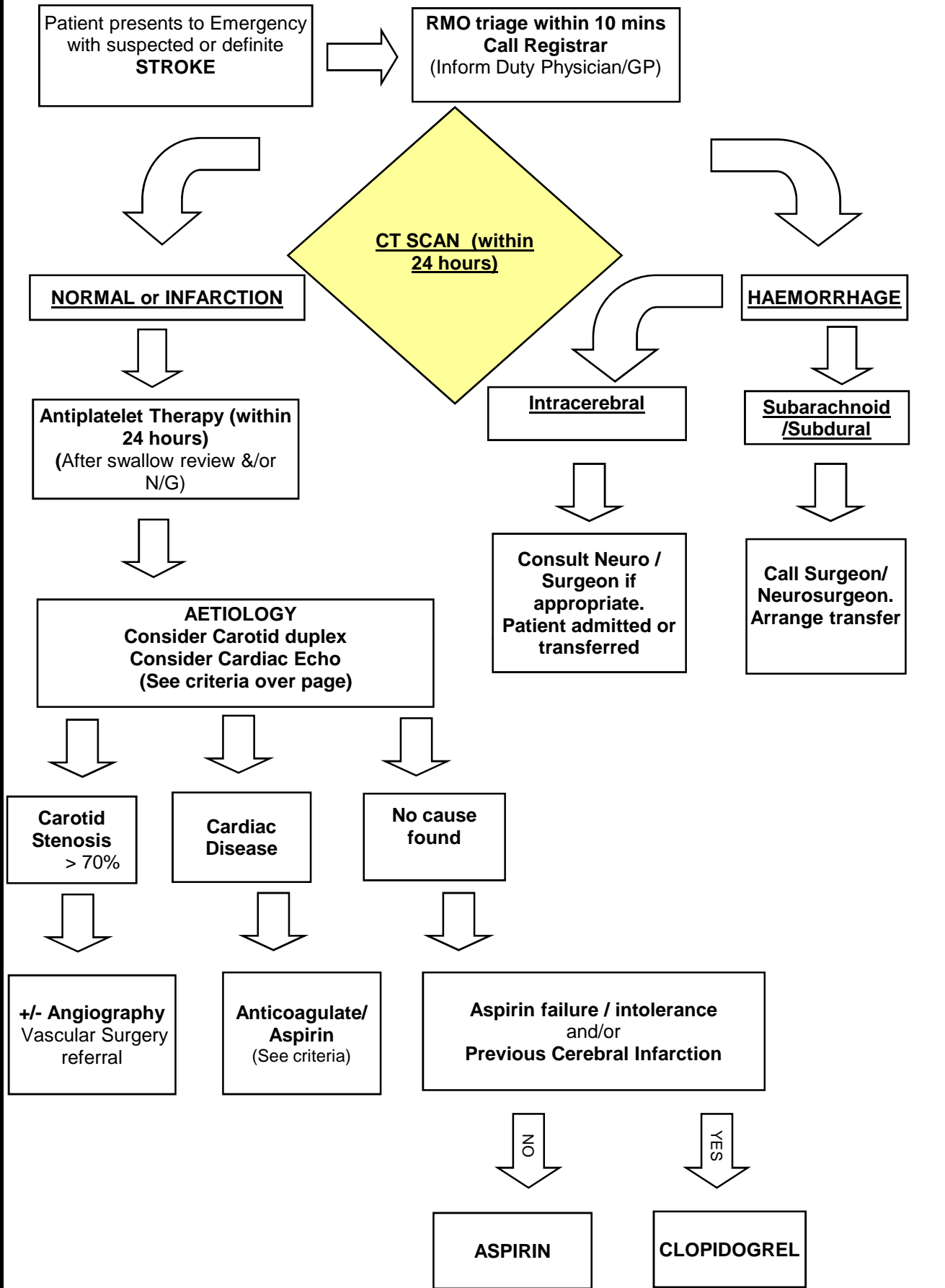
if variance

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CLINICAL PATHWAY - STROKE ALGORITHM

EMERGENCY DEPT

INPATIENT



Source: Adapted from Box Hill Hospital Stroke Clinical Pathway 1998

STROKE MANAGEMENT AT WIMMERA HEALTH CARE GROUP

CEREBRAL INFARCTION (Ischaemic Stroke)

Ischaemic changes may not be obvious on CT scan for 3-5 days after stroke onset.

Possible Causes:

- Atrial Fibrillation
- Carotid stenosis.

Investigations required include:

1. Carotid duplex – for all patients with cerebral infarction who are suitable for carotid endarterectomy / angioplasty. Referral to a vascular surgeon should be considered for patients found to have an ipsilateral symptomatic carotid stenosis of greater than 70%.
2. Echocardiography – is useful for detection of embolic sources and conditions related to an increased risk of stroke, such as atrial fibrillation, enlarged left atrium and/or ventricle, thrombus, vegetation and mitral stenosis.
3. Telemetry / Holter Monitor where appropriate.
4. Trans-oesophageal Echocardiography to exclude endocarditis where appropriate.
5. aPTT, INR, platelet count to assess clotting disorders and vasculitis.

INTRACEREBRAL HAEMORRHAGE

Intracerebral haemorrhage management is mostly supportive. Cerebellar haematomas may respond to surgery and referrals should be made urgently if the conscious state is deteriorating or depressed. Evidence has not proven that use of dexamethasone or mannitol is beneficial. Subarachnoid or subdural haemorrhage requires immediate surgical consultation and probable transfer to a neurosurgical unit.

MEDICATION FOR TREATMENT OF ACUTE ISCHAEMIC STROKE

Thrombolytics [NOT CURRENTLY USED at Wimmera Health Care Group due to delays in after hours CT reporting]

Intravenous rtPA is recommended for carefully selected patients who can be treated within 3 hours of onset of ischaemic stroke. Therapy should be initiated as soon as possible to optimise benefits. Strict inclusion/exclusion criteria exist, as treatment with rtPA is associated with symptomatic intracranial haemorrhage, which can be fatal. Close observation and monitoring of the patient after administration is critical. Anticoagulants and antiplatelet agents should be delayed for 24 hours after treatment.

Antiplatelets

For patients who do not receive thrombolysis, aspirin should be given as soon as possible after the onset of symptoms of **ischaemic stroke**. Dose is 150 to 300mg, to be administered after CT to exclude haemorrhage and after swallow assessment to determine need for thickened fluids or nasogastric tube. Ensure dose is received within 48 hours of stroke onset.

Full-dose anticoagulation- not recommended

Full-dose anticoagulation with unfractionated heparin, low-molecular weight heparin (eg. enoxaparin) or danaparoid is not recommended (even in ischaemic stroke) because of an increased risk of serious bleeding complications. These medications increase the risk of symptomatic haemorrhagic transformation of ischaemic stroke and increase the risk of bleeding in other parts of the body.

Thromboprophylaxis

In post **ischaemic stroke** patients with restricted mobility and no contra-indications, use:

1. Enoxaparin (Clexane®) 20mg s/c daily, or
2. Unfractionated heparin 5,000 units s/c twice daily

TED stockings should be used on all patients with limited mobility.

Heparin may be used safely in combination with antiplatelet agents.

MEDICATION FOR ISCHAEMIC STROKE PREVENTION

Antiplatelets

Every patient who has experienced a non-cardioembolic stroke or TIA and has no contra-indication should receive regular antiplatelet therapy. Use:

1. Asasantin SR® (aspirin 25 mg / sustained release dipyridamole 200 mg) twice daily^{9,10}, or
2. Aspirin 100 mg to 150 mg daily, or
3. Clopidogrel 75 mg daily

Asasantin SR® is more effective than aspirin or clopidogrel monotherapy, but may cause headaches.

Clopidogrel monotherapy is slightly more effective than aspirin monotherapy but is only available on the PBS for patients who have previously been on aspirin which failed, or who are intolerant or allergic to aspirin.

Clopidogrel + Aspirin combination has a higher risk of major bleeding than either agent used alone without improved effectiveness.

Oral anticoagulants

Long-term anticoagulation with warfarin is recommended for prevention of stroke in patients with atrial fibrillation or other high-risk cardiac diseases (such as myocardial infarction less than two months previously, significant valve disease, left atrial or left ventricular thrombus, cardiomyopathy, previous embolus, prothrombotic disorder, provided there are no contra-indications (including inability of patient to manage warfarin regime).

An antiplatelet e.g. aspirin is otherwise recommended.

Initiation of warfarin after ischaemic stroke depends on the risk of recurrent thromboembolism and the risk of haemorrhagic transformation. Generally, treat patients with acute ischaemic stroke with an antiplatelet and consider commencement of warfarin 1 to 2 weeks after stroke onset. (recommended target INR of 2.5: range 2.0 to 3.0). If patient is on warfarin prior to a minor ischaemic stroke or TIA, consider continuing warfarin therapy.

BLOOD PRESSURE CONTROL

Acute Stages

An elevated BP can result from the stress of the stroke, a full bladder, pain, pre-existing hypertension, a physiological response to hypoxia, or increased intracranial pressure.

Aggressive treatment of elevated BP could be detrimental due to secondary reduction of perfusion in the area of ischaemia. The consensus is that antihypertensive agents should be withheld unless the diastolic BP is > 120 mmHg or unless the systolic BP is > 220, then aim for a reduction of 10-15%, using a cautious approach with short acting agents such as GTN patch.

Prior to Discharge

Evidence from the PROGRESS trial showed that perindopril in combination with indapamide (Coversyl plus®) used after stroke reduces the risk of secondary stroke, even if antihypertensive therapy is **not** indicated. (PROGRESS trial, Lancet, 2001;358;1033-1041).

CHOLESTEROL MANAGEMENT

Consider treatment with statins if total cholesterol > 3.5. Trials have shown a significant reduction of stroke by the use of lipid lowering agents in patients with coronary artery disease (Heart Protection Study, Lancet 2002;360:7-22). Pravastatin significantly reduces stroke or TIA incidence after myocardial infarction in patients with average serum cholesterol levels (CARE study). Intensive cholesterol reduction with Atorvastatin 80 mg reduces the risk of recurrent cerebrovascular events in patients with recent stroke or TIA but no history of heart disease (SPARCL study).

HYPERGLYCAEMIA MANAGEMENT

Hyperglycaemia aggravates brain injury, It is recommended a judicious approach to management of hyperglycaemia, treating BGL > 10 with insulin. Blood glucose levels should be monitored; Intravenous administration of glucose-containing solutions should be avoided. Overly aggressive therapy should be avoided because it can result in fluid shifts, electrolyte abnormalities, and hypoglycaemia, all of which can be detrimental to the brain. (Adams et al, 2003, p 1064-5)

NUTRITION

Patient is to remain Nil By Mouth, (NBM) until assessed by speech pathologist, or has had Out of Hours Dysphagia Screening Test conducted by a Dysphagia Trained Nurse (DTN). If Out of Hours assessment is satisfactory passed the patient may proceed to Level 2 fluids and vitamised diet. Patients who are NBM should have a nasogastric tube inserted in Emergency Department, followed by an X-ray to nasogastric check position. A Flexiflo® tube is suggested being narrow gauged and soft, resulting in improved tolerance. Early hydration and instigation of nutrition is advised. Patients should have intravenous therapy, (avoid dextrose solutions) until enteral hydration is commenced.

Enteral Feeding Guide (When Dietitian is unavailable): Continuously 06:00 hours to 22:00 hours using Flexiflo Companion Pump. Not overnight, due to risk of aspiration.

Day 1: Use water 50mL per hour for 4 hours then change to Jevity 50mL per hour.

Day 2: Jevity 75 mL per hour

Water flushes: 50mL every 4 hours, or whenever giving any medication, to prevent blockages. Medication should be crushed and mixed with small amount of warm water. Not all medications should be crushed or will pass through a narrow gauge nasogastric tube (refer to protocol).

References

1. Adams HP et al. *Guidelines for the Early Management of Patients with Ischaemic Stroke*. Stroke 2003;34:1056-1083.
2. Albers GW, Amarenco P, Easton JD, Sacco RL, Teal P. *Antithrombotic and thrombolytic therapy for ischaemic stroke*. Chest 2001 Jan; 119 (1 Suppl):300S-320S.
3. Australian Medicines Handbook, 2008
4. Box Hill Hospital Stroke Clinical Pathway 1998
5. Hankey GJ. *Non-valvular atrial fibrillation and stroke prevention*. MJA 2001; 174:234-348
6. Pushpangadan M, Wright J, Young J, (1999) Evidence-based guidelines for early stroke management. Hospital Medicine 60:2 105-114
7. Royal College of Physicians (1999) National Clinical Guidelines for Stroke at www.rcplondon.ac.uk/ceeu_stroke_home.htm.
8. www.pbs.gov.au (2007)
9. Lancet Vol 367 20 May 2007 ESPRIT trial
10. Stroke 2005;36:162-168

These recommendations were developed as evidence based guidelines.

Variations in care may be required on an individual basis, however they should be documented with substantiation.

PHYSIOTHERAPY ASSESSMENT Blanket referral on day 1 STROKE CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP - HORSHAM	Patient ID _____
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RESPIRATORY Auscultation _____ Cough _____ Sputum _____ Oxygen therapy _____	COGNITION / PERCEPTION (<input checked="" type="checkbox"/> INTACT <input checked="" type="checkbox"/> AFFECTED) <input type="checkbox"/> Conscious state <input type="checkbox"/> Attention span <input type="checkbox"/> Follow instructions <input type="checkbox"/> STM <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> General communication Neglect Y / N Sensory inattention Y / N Orientation: <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person
-------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Dominance R / L	Affected side R / L	Shoulder	Subluxation Y / N Pain Y / N
Coordination			
Finger nose:	R /15s L /15s		Light touch
Alt sup / pronation:	R NAD < > = L		UL /5
Heel shin:	R Unable / Able L Unable / Able		LL /5
Sensation			
Proprioception: UL Thumb /3 Wrist /3 Elbow /3			
LL Great toe /3 Ankle /3 Knee /3			
Tone		Power	
UL	Normal Increased Decreased	UL	Proximal /5 Distal /5
LL	Normal Increased Decreased	LL	Proximal /5 Distal /5

Mobility / Function	Comment
Supine to side	
Bridging	
Supine to sitting over edge of bed	
Sitting balance	
Sitting to standing	
Standing balance	
Walking	
Proximal UL function	
Distal UL function	

Recommended transfers

Comments

Expected discharge destination

Physiotherapist _____ Date _____

OCCUPATIONAL THERAPY ASSESSMENT

Blanket referral on day 1
 STROKE CLINICAL PATHWAY
 WIMMERA HEALTH CARE GROUP - HORSHAM

Patient ID

Premorbid Information

Lives alone: Yes No

I = Independent, A = Assisted, D = Dependent, S = Shared, N = Non applicable

Self Care

Eating
 Grooming
 Bathing/Showering
 Dressing
 Medication

Domestic

Meal Preparation
 Housework
 Laundry
 Home maintenance

Community

Transport
 Finances
 Shopping
 Leisure

Other _____

Family/Social supports: _____

Community Support Services:

Home.H

MOW

DNS

S.L

Home set-up

House Flat Unit Nursing Home Hostel Other: _____

Owned Rented Boarding Other: _____

Access:

Front: _____

Back: _____

Internal: _____

Bathroom: _____

Toilet: _____

Bedroom: _____

Other: _____

Need for Home assessment: Yes No

Upper Limb Function

Upper Extremity ROM: _____

Upper Extremity Strength: _____

Dominance: Right Left

Hand Strength:

Grasp: Right Left

3 pt. Pinch: Right Left

Coordination:

Gross: Right Left

Fine: Left Left

Limiting Factors: _____

	Right			Left		
	Intact	Impaired	Absent	Intact	Impaired	Absent
Sensation:						
Proprioception						
Sharp / Dull						
Light Touch						
Stereognosis						
Hot/Cold						

Subluxation: Yes No

Affected: Right Left

Pain: Yes No

Neither:

Shoulder Care Required: Yes No

Sling/collar & cuff for transfer

Visu-alert arm band

Shoulder care bed card

BARTHEL INDEX		A	B	C	D	COMMENTS		
SELF CARE INDEX	1. Drinking from a cup	4	2	0	0	Key: A= Can do without aids B=Can do with aids C= Can do with help D= Cannot do at all.		
	2. Eating	6	3	0	0			
	3. Dressing upper body	5	5	3	0			
	4. Dressing lower body	5	5	2	0			
	5. Putting on a brace or artificial limb	0	0	-2	N/A 0			
	6. Grooming	5	5	0	0			
	7. Washing or bathing	4	4	0	0			
	8. Controlling urination	10	10	5	0			
			Accidents		Incontinence			
	9. Controlling bowel movements	10	10	5	0		Subtotal	
		Accidents		Incontinence				
10. Care of perineum/clothes at toilet	4	4	2	0	53			
MOBILITY INDEX	11. Getting in and out of chair	15	15	7	0			
	12. Getting on and off toilet	6	5	3	0			
	13. Getting in and out of bath or shower	1	1	0	0			
	14. Walking 50 yards on the level	15	15	10	0	Subtotal		
	15. Walking up / down one flight of stairs	10	10	5	0	47		
	16. IF NOT WALKING Propelling / pushing wheel chair	15	5	0	0	TOTAL SCORE		
						100		

ABBREVIATED CEREBRAL FUNCTION TEST	SCORE	COMMENTS
1. Age	<input type="checkbox"/>	
2. Time (to nearest hour)	<input type="checkbox"/>	
3. Address for recall at end of test (42 West street)	<input type="checkbox"/>	
4. Year	<input type="checkbox"/>	
5. Name of Hospital:	<input type="checkbox"/>	
6. Recognition of two persons: (Doctor/Nurse)	<input type="checkbox"/>	
7. Date of Birth	<input type="checkbox"/>	
8. Year of first World War	<input type="checkbox"/>	
9. Name of present Prime Minister	<input type="checkbox"/>	
10. Count backwards, Twenty to One:	<input type="checkbox"/>	
		Score
		10

Patient confused: Yes No

Need for further cognitive screening: Yes No

SSMSE: Section 1.

1. Year	1	<input type="checkbox"/>	6. Country	1	<input type="checkbox"/>
2. Season	1	<input type="checkbox"/>	7. State	1	<input type="checkbox"/>
3. Month	1	<input type="checkbox"/>	8. Town	1	<input type="checkbox"/>
4. Date	1	<input type="checkbox"/>	9. Place	1	<input type="checkbox"/>
5. Day	1	<input type="checkbox"/>	10. Building	1	<input type="checkbox"/>

Depression scale completed

Yes No

Score

15

Section 2.

11. Word 1	14. Wristwatch	19. Sentence
Word 2	15. Pencil	20. Figure copying
Word 3	16. No if's and's or but's	
12. DLROW	17. Subject closes eyes	
13. Word 1	18. Paper in correct hand	
Word 2	Folds it in half	
Word 3	puts it on floor	

TOTAL SCORE

30

Signature **Print name**
Date

NUTRITIONAL ASSESSMENT
Blanket referral on day 1
STROKE CLINICAL PATHWAY
WIMMERA HEALTH CARE GROUP - HORSHAM

Patient ID _____

1. Indication for nutritional intervention:

- | | |
|------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Nil orally > 48 hrs | <input type="checkbox"/> Unconscious / decreased conscious state |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Anorexia / inadequate oral intake |
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Dietary related risk factors for stroke |
| <input type="checkbox"/> Other (specify) _____ | specify: _____ |

2. Nutritional assessment:

a) Anthropometry:

Weight _____ (kg) (est./meas.) BMI _____ kg/m²
 Height _____ (kg) (est./meas.) Ref. Weight range: _____ kg.
 Weight history - _____

b) Summary of usual diet/clinical observations:

c) Estimated nutritional requirements (for enteral feeding purposes only):

Energy (schofiend Eqn.x AF X SF) = _____ Mj
 Protein (_____g/kg bw) = _____ g
 Fluid requirement/restriction = _____ ml

3. Nutritional support:

Nil orally until further assessment: _____ Date: _____
 I.V. fluids: Yes / No Rate: _____
 Enteral support (specify) _____ Date commenced: _____

 Oral intake: _____ Date commenced: _____

■ Meal consistency: Vitamised Minced Soft Full

■ Fluids: Thickened, Level 1 / 2 / 3 / 4 Thin
 (circle number)

■ Supplements issued (specify): _____

■ Special dietary requirements/preferences (specify): _____

DIETITIAN _____ DATE _____

SPEECH PATHOLOGY ASSESSMENT
Blanket referral on day 1
STROKE CLINICAL PATHWAY
WIMMERA HEALTH CARE GROUP - HORSHAM

Patient ID _____

A. COGNITION

- *Conscious state* Unconscious Drowsy Alert Fluctuating
- *Orientation* Person Place Time
- *A. V. Recall / New Learning* Normal Impaired date: _____
- *Verbal Reasoning* Normal Impaired date: _____

B. COMPREHENSION

- *Simple/Basic Requests* Normal Impaired date: _____
- *Social Conversation* Normal Impaired date: _____
- *Complex/Abstract Info* Normal Impaired date: _____

C. EXPRESSION date: _____

- *Reliable yes/no* Normal Impaired
- *Characteristics of verbal output*
 - Normal Nonverbal Jargon
 - Fluent Nonfluent Word finding difficulties
 - Perservation Paraphasias *Other* _____

● *Functional Communication (Therapy Outcome Measure Dysphasia Scale: Enderby et al, 1997)*

0	1	2	3	4	5
None	Basic Needs	Basic Needs	Needs (indep)	Conversation	Conversation
Dependent	Max Assist.	Mod Assist.	Conversation (Mod Assist)	Min Assist.	Indep.

D. LITERACY date: _____

- *Intact at Premorbid Level* yes no
- *Reading Level* _____
- *Writing Level* _____

E. OROMOTOR date: _____

- *Cranial Nerve Function* CN V _____ CN VII _____
 CN IX/X _____ CN XII _____

● *Level of intelligibility (Therapy Outcome Measures Dysarthria Scale: Enderby et al, 1997)*

0	1	2	3	4	5
None	Basic Needs	Basic Needs	Needs (indep)	Conversation	Conversation
Dependent	Max Assist.	Mod Assist.	Conversation (Mod Assist)	Min Assist.	Indep.

F. SWALLOWING date: _____

● *Dysphagia Scale (Royal Brisbane Hospital Outcome Measure for Swallowing, 1997)*

1	2	3	4	5	6	7	8	9	10
/ Nil by Mouth		/Commencing Oral Intake /			Establishing Oral Intake /		Maintaining Oral Intake /		

- *Modified Diet* yes no
- Fluids* PEG NGT IV Level 4 Level 3 Level 2 Level 1 Thin
- Solids* PEG NGT IV Vitamised Minced Soft Full Ward
- Medication* Normal Crushed Liquid Only IV/NGT/PEG

SUMMARY

RECOMMENDATIONS

GOALS & TIMELINES

Speech Pathologist _____ Signature: _____ Date _____

**CONTINENCE ADVISOR
CLINICAL PATHWAY
WIMMERA HEALTH CARE GROUP**

Pt. ID Label

Date: _____ Day _____

Bladder and Bowel Symptom Assessment Completed

Yes

No

Outcome of assessment or why assessment not completed

MANAGEMENT PLAN:

Please ensure Signature Register is completed

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP	Pt. ID Label
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After Hours Dysphagia Screening Protocol

To be completed by a Dysphagia Trained Nurse (DTN) when Speech Pathologist not available.					
PART A- Observed Behaviours		EMERGENCY DEPT		24 HOURS POST STROKE	
		Date		Date	
	Behaviour	Yes	No	Yes	No
Cognition	Is patient alert, awake, and responding to questions?		cease screen		cease screen
Posture	Is patient sitting up in bed or chair?		cease screen		cease screen
Oromotor	No obvious facial weakness or slurred speech		cease screen		cease screen
Oro-pharyngeal secretions	No drooling, is patient able to swallow own saliva.		cease screen		cease screen
Protective reflexes	Is patient able to cough? Is voice clear? - not gurgly.		cease screen		cease screen

<i>If All Yes responses in Part A continue to Part B</i>					
PART B- Oral trial		EMERGENCY DEPT		24 HOURS POST STROKE	
		Date		Date	
	Behaviour	Yes	No	Yes	No
Thickened Fluids (Level 2) (Honey Consistency)	Timely Visual swallow (<2 seconds)		cease screen		cease screen
	No coughing or choking (<i>immediate or delayed</i>)		cease screen		cease screen
	No shortness of breath		cease screen		cease screen
	Voice is clear post swallow (<i>Not wet or gurgly</i>)		cease screen		cease screen
Vitamised Solid	Able to clear food from mouth		cease screen		cease screen
	Timely Visual swallow (<2 seconds)		cease screen		cease screen
	No coughing or choking (<i>immediate or delayed</i>)		cease screen		cease screen
	No shortness of breath		cease screen		cease screen
	Voice is clear post swallow (<i>Not wet or gurgly</i>)		cease screen		cease screen

PART C- Outcomes				
RESULT		OUTCOME	TICK	DTN SIGNATURE
(i) Failed either section A or B		Patient remains Nil Orally	<input type="checkbox"/>	print name:
(ii) Passed both sections A & B (<i>all 'yes' after 5 teaspoons</i>)		Patient commence Level 2 fluids & vitamised diet	<input type="checkbox"/>	print name:

Document outcomes on pathway
All patients to be referred to Speech Pathology

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP	Pt. ID Label
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CLASSIFICATION SCALES

TIA Risk Stratification		
ABCD Score	Risk factor	Points
Age	≥ 60 years	1
Blood pressure	Systolic >140mmHg and/or	1
	diastolic ≥90mmHg	1
Clinical features	Unilateral motor weakness	2
	Speech disturbance without weakness	1
	Other	0
Duration of symptoms	≥ 60 min	2
	10-59 min	1
	< 10 min	0
SCORE Calculated		
<i>If above 5 or 6 manages as ischaemic stroke</i>		

ABCD Score - 7 day risk of stroke after a TIA
 Score of 0-3, 0% risk Score of 4, 2.2% risk Score of 5, 16.3% risk Score of 6, 35.5% risk

Oxfordshire Classification Scale				
	1	Unilateral weakness and/or sensory deficit affecting face		
	2	Unilateral weakness and/or sensory deficit affecting arm / hand		
	3	Unilateral weakness and/or sensory deficit affecting leg / foot		
	4	Dysphasia, dyslexia, dysgraphia (i.e. non-dominant hemisphere)		
	5	Neglect / inattention / spatial disorder (i.e. non-dominant hemisphere)		
	6	Homonymous hemianopia or quadrantanopia		
	7	Brainstem / cerebellar signs other than ataxic hemiparesis		
Classification: Using the above features, identify stroke classification			30 day mortality	
			3 month recurrence	
	1+2+3+ one or both 4 / 5	TACI (total anterior circulation infarct) worst stroke - occlusion of proximal MCA	39%	Low
	1 +/-2 +/-3 +(4 or 6) or (5 or 6)	PACI (partial anterior circulation infarct) Large vessel occlusion but less than above	4%	Very High
	1 +/-2 +/-3 (not 4, 5, 6, or 7)	LAC (lacunar infarct) small vessel occlusion - subcortical	2%	Low
	7 +/- (6 or (6 +/-1 +/-2 +/-3))	POCI (posterior circulation infarct)	7%	High
	other			

Modified Rankin Scale	
0	No symptoms at all (no limitations and no symptoms)
	No significant disability despite symptoms: able to carry out all usual duties and activities.
1	Question: Does the person have difficulty reading or writing, difficulty speaking or finding the right word, problems with balance or coordination, visual problems, numbness (face, arms, legs, hands, feet), loss of movement (face, arms, legs, hands, feet), difficulty with swallowing, or other symptom resulting from stroke?
	Slight disability: unable to carry out all previous activities but able to look after own affairs without assistance.
2	Questions: Has there been a change in the person's ability to work or look after others if these were roles before stroke? Has there been a change in the person's ability to participate in previous social and leisure activities? Has the person had problems with relationships or become isolated?
	Moderate disability: requiring some help but able to walk without assistance.
3	Question: Is assistance essential for preparing a simple meal, doing household chores, looking after money, shopping, or traveling locally?
	Moderate to severe disability: unable to walk without assistance and unable to attend to own bodily needs without assistance.
4	Question: Is assistance essential for eating, using the toilet, daily hygiene, or walking?
	Severe disability: bedridden, incontinent and requiring constant nursing care and attention.
5	Question: Does the person require constant care?
6	Death

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP	Pt. ID Label
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RMO	Initial	Date: _____	Emergency Department
History Exam		Patient seen by RMO / Registrar within 15 minutes of arrival	
Time of onset:		Accurate _____ approximately between _____ Sleep (time retired to bed) _____	
Investigations		CT Brain to be completed within 24 hours of admission. Immediate - associated with head injury, suspicion of subarachnoid haemorrhage impaired or deteriorating level of consciousness Semi urgent: Minor stroke syndromes, Trans-ischaemic attacks, stable acute deficit for 24 hours or longer CT Brain interim report by: _____ Results: (circle) Normal Infarction Haemorrhage Lacune Location: _____ ECG: (circle) Atrial Fibrillation / Sinus rhythm Other: _____ Arterial Blood Gases if SaO2 <92% on air FBE, U&E, LFT, Glucose, PT, INR, aPPT (emergency department) Fasting Chol, Trigs, HDLs, Glucose, ESR & Homocysteine (ordered for day 1) If age<50 do Protein C&S, PCR, AN3, ANS, LUP, Proth 20210 (ordered for day 1) Chest X-Ray only if indicated, (Required to check Nasogastric placement) Oxfordshire Classification (see scale for on reverse): Please complete Results: (circle) TACI PACI LACI POCI Other TIA risk stratification (see scale for on reverse): Score _____ High risk TIA score 5 & 6 to be admitted and managed as acute ischaemic stroke	
Management		'Nil orally' if swallow assessment failed: DTN / Speech pathologist to complete swallow assessment Aspirin ordered if stroke is ischaemic or CT negative (withhold if nil orally) Consider need for sliding scale (BGL >10mmol / L) Senior Registrar to consider need for NFR order Discuss diagnosis / plan with patient / family	
Risk Factors		Diabetes Cardiac arrhythmia Ischaemic heart disease Hypertension Peripheral vascular disease Previous stroke / TIA Other cardiac abnormalities _____ Thrombosis risk	Smoking Alcohol Raised Lipids Family history Hormone replacement therapy Oral contraception Genetic coagulation defects Recent head injury*
		* If recent head injury and altered level of consciousness, consider subdural haemorrhage and CT priority 1.	
Date/Time		Progress Notes/Variance (V black circled) with reason if known, followed by Action/Treatment/Outcome, sign entry	
		Please ensure Signature Register is completed	

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
Date: _____ Admission Day		AM	PM	ND	Comments
Key Task - Antiplatelet therapy if Ischaemic Stroke/TIA . Avoid sedatives & aggressive BP control.					
CNS	Neuro obs 1/24 for first 6 hours then 2-4/24 if stable GCS _____ Conscious state _____ No deterioration in conscious state Neurological deficit _____ Patient comfortable, no pain relief required Patient communication is verbal / nonverbal / absent (circle)				Admitted to ward at _____
CVS	4/24 TPR and BP if stable (Postural BP done b.d. if possible) Patient afebrile and haemodynamically stable Has request slip present for 06:00 am fasting bloods Fasting bloods taken as ordered (06:00 hours - night staff) Telemetry for 24 hours				treat fever > 37.5
DVT prophylaxis	Ankle / leg exercises 1/24 when awake Graduated Compression Stockings in place (until mobile)				
Respiratory	Oxygen if SaO ₂ < 95% or impaired conscious state Patent airway maintained / no respiratory distress Nasopharyngeal suction required Yes No (circle)				
GIT/Hydration	IV Site checked t.d.s. Site clean and dry Nil orally until swallow assessed Swallow screening completed by Speech Pathology After hours, DTN* completes a repeat swallow screen: Meds and fluids given by : Oral, N/G, IV, PR, (circle) Fluids: Thin, Thick (Level 1 2 3 4), NG, Nil orally (circle) Diet: Full, Soft, Minced, Vitamised, Nil orally (circle) Vitamised / Thick (Level 2) or Nil orally only (circle) FBC maintained Bowels open (circle) Continent Incontinent				DTN = dysphagia trained nurse
Renal/Urinary	Urine: Continent Incontinent IDC (circle) Referral to Continence Nurse if patient incontinent Bladder scan completed within 12 hours of admssion Post void residual volume: _____ Urinary output > 300 mL per shift Urinalysis: NAD				
Endocrine	BGL daily (all patients) , q.i.d. if diabetic or elevated BGL < 10 mmol / L Written referral sent to Diabetes Educator (diabetic patients)				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Area Risk (waterlow) Score _____ appropriate strategies in place Patient washed (Specified) _____ Mouth and Eye care completed				
Mobility	Patient positioned to avoid risks. Specify _____ Head elevated 30 degrees (to decrease aspiration risk) 'No Lift' assessment completed, appropriate strategies in place Specify: Rest in bed Sit out of bed (circle) Falls Risk assessment score _____ appropriate strategy in place				
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Concerns identified / documented, emotional support provided				
Discharge Plan	Discharge Risk Score _____ (coordinator notified if risk score >5)				
Please ensure Signature Register is completed					

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
	Date: _____ Day 1 - Post Stroke	AM	PM	ND	Comments
CNS	Neurological obs 4/24 for 48 hours (<i>more frequent if unstable</i>) GCS ____/15, Conscious state _____ No deterioration in conscious state Patient comfortable, no pain relief required Communication is unimpaired / impaired; verbal / nonverbal / absent				(circle)
Speech Path	Speech Pathologist Communication Assessment completed				
CVS	TPR and BP 4/24 (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				treat fever > 37.5 with antipyretics
DVT prophylaxis	Ankle / leg exercises 1/24 when awake Graduated Compression Stockings in place (<i>until mobile</i>)				
Medications	Review by Pharmacist Medications given; Oral / Nasogastric / PR / IV Medication given as per MR 10				
Respiratory	No respiratory distress Oxygen if SaO ₂ < 95% or impaired conscious state Nasopharyngeal suction required Yes / No				
GIT/Hydration	IV Site checked t.d.s. Site clean and dry IV removed if adequate hydration				NOT TO HAVE THIN FLUIDS UNTIL REASSESSED BY SPEECH PATHOLOGIST See Stroke Management guide to commence enteral feeds, (when Dietitian unavailable)
Swallow Assessment	Repeat Swallow assessment completed if Nil orally Fluids (circle): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (circle): Full, Soft, Minced, Vitamised, Nil orally Nasogastric feeds: Type and Amount _____ FBC maintained Bowels open (circle) Continent Incontinent				
Dietitian	Dietitian assessment completed (weekdays)				
Renal/Urinary	Urine (circle) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (<i>300 mL / shift</i>) Consider Cranberry Juice / Capsules if IDC in situ				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure risk assessed _____ P/Care _____ Specify aids needed (<i>As per strategy</i>) _____ Mouth and eye care completed General hygiene completed (circle); Shower, Sponge				
Occupational T	OT assessment & Barthels / Hodkinsons				
Mobility	Patient positioned to avoid risks. Specify _____ 'No Lift' assessment reviewed Falls Risk assessment score _____ appropriate strategy in place Physiotherapist assessment completed Passive full range of motion exercises for paralysed limbs Care of shoulder _____ Head elevated 30 degrees Rest in bed Sit out of bed (circle)				
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient & family Nursing Risk Assessment form (<i>MR 68</i>)- reviewed Education commenced for TIA and minor stroke patients				
Social Work	Social Work consult, assessment completed (<i>week days</i>) Stroke package / TIA package given to patient / carer				
Discharge Plan	Discuss Discharge plan if appropriate (<i>TIA</i>)				
Please ensure Signature Register is completed					

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
Date: _____ Day 2		AM	PM	ND	Comments
CNS	Neurological obs 4/24 for 48 hours (<i>more frequent if unstable</i>) GCS ____ /15, Conscious state _____ (am) No deterioration in conscious state Head elevated 30 degrees Patient comfortable, no pain relief required Communication is unimpaired / impaired; verbal / nonverbal / absent				(circle)
CVS	TPR and BP 4/24 (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				treat fever > 37.5 with antipyretics
Medications	Review by Pharmacist Medications (circle); Oral, Nasogastric, PR, IV Medications given as per MR 10				
Respiratory	No respiratory distress Oxygen if SaO ₂ < 95% or impaired conscious state Nasopharyngeal suction required Yes / No				
GIT/Hydration	IV Site checked t.d.s. Site clean and dry IV removed if adequate hydration / no IV medications				
Speech Path	Swallow assessment by Speech Pathologist Fluids (circle): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (circle): Full, Soft, Minced, Vitamised, Nil orally Nasogastric feeds: Type and Amount _____ FBC maintained Bowels open (circle) Continent Incontinent				NOT TO HAVE THIN FLUIDS UNTIL REASSESSED BY SPEECH PATHOLOGIST See Stroke Management guide to commence enteral feeds, (when dietitian unavailable)
Dietitian	Dietitian assessment completed (weekdays)				
Renal/Urinary	Urine (circle) - Continent Incontinent IDC / Condom Referral to Continence Nurse (<i>if patient is incontinent</i>) Urinary output >30 mL / hour (300 mL / shift)				
Continence Nr	Continence assessment completed, (<i>if patient is incontinent</i>)				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure risk assessed _____ P/Care _____ Specify aids needed (<i>as per strategy</i>) _____ Mouth and eye care completed General hygiene completed (circle); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment & Barthels / Hodkinsons				
Mobility	Patient positioned to avoid risks. Specify _____ 'No Lift' assessment reviewed Falls risk assessment score _____ appropriate strategy in place Physiotherapist assessment completed Passive full range of motion exercises for paralysed limbs Care of shoulder _____ Head elevated 30 degrees Rest in bed Sit out of bed (circle) Mobility _____ Gait Aid _____				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education provided as per plan				
Discharge Planning	Discuss 'Discharge Plan' if appropriate If short-term stay MR 68 discharge plan completed				Family meeting:
Social Work	Social Work consult (stroke package given and discussed)				
ALL STAFF:	Please ensure Signature Register is completed				

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
Date: _____ Day 3					
CNS	Neurological obs q.i.d. or as ordered GCS _____ Conscious state _____ No deterioration in conscious state Patient is able to rest / sleep when appropriate Patient comfortable, no pain relief required Communication is unimpaired / impaired; verbal / nonverbal / absent				(circle)
CVS	TPR and BP 4/24 (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				treat fever > 37.5 with antipyretics
Medications	Review by Pharmacist Medications given as per MR 10 Medications (circle); Oral, Nasogastric, PR, IV Education provided if appropriate				
Respiratory	No respiratory distress Oxygen if SaO ₂ < 95% or impaired conscious state Nasopharyngeal suction required Yes / No				
GIT/Hydration	IV Site checked t.d.s. Site clean and dry IV removed if adequate hydration / no IV medications Fluids (circle): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (circle): Full, Soft, Minced, Vitamised, Nil orally Nasogastric feeds: Type and Amount _____ Food and fluids tolerated FBC maintained Bowels open (circle) Continent Incontinent Give aperient if BNO since admission				See Stroke Management guide to commence enteral feeds, (when dietitian unavailable)
Renal/Urinary	Urine (circle) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (300 mL / shift) Consider Cranberry Juice / Capsules if IDC in situ				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Risk assessed _____ P/Care _____ Specify Aids needed (<i>As per strategy</i>) _____ Mouth and Eye care completed General Hygiene completed (circle); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment, Barthels / Hodkinsons				
Mobility	'No Lift' assessment reviewed Mobilise as per Physio / nursing review Falls Risk assessment score _____ appropriate strategy in place RIB (TEDs / Leg ex) SOOB Ambulate Passive full range of motion exercises for paralysed limbs Care of shoulder _____ Head elevated 30 degrees Rest in bed Sit out of bed (circle)				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education of patient / family provided as per plan				
Discharge Plan	Discuss Discharge plan if for short-term stay				Family Meeting:
Social work	Multidisciplinary family meeting required, (Circle) Yes No Social Work consult (<i>stroke package given and discussed</i>)				
ALL STAFF: Please ensure Signature Register is completed					

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
	Date: _____ Day 4	AM	PM	ND	Comments
CNS	Conscious state assessed (<i>specify</i>) _____ No deterioration in conscious state Patient is able to rest / sleep when appropriate Patient comfortable, no pain relief required Communication is unimpaired / impaired; verbal / nonverbal / absent				(<i>circle</i>)
CVS	TPR and BP 4/24 (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				
Medications	Review by pharmacist Medications given as per MR 10 Medications (<i>circle</i>); Oral, Nasogastric, PR, IV Education provided if appropriate				
Respiratory	No respiratory distress Oxygen if SaO ₂ < 95% or impaired conscious state Nasopharyngeal suction required Yes / No				
GIT/Hydration Speech Path	IV Site checked t.d.s. Site clean and dry IV removed if adequate hydration / no IV medications Fluids (<i>circle</i>): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (<i>circle</i>): Full, Soft, Minced, Vitamised, Nil orally Repeat Swallow assessment (Speech Path) if appropriate Nasogastric feeds: Type and Amount _____ Food / fluids tolerated FBC maintained Bowels open (<i>circle</i>) Continent Incontinent Consider aperient if BNO for 2 days				
Renal/Urinary	Urine (<i>circle</i>) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (<i>300 mL / shift</i>) Reassess incontinence. Consider removal of IDC				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Risk assessed _____ PAC _____ Mouth and Eye care completed General Hygiene completed (<i>circle</i>); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment, Barthels / Hodkinsons				
Mobility	'No Lift' assessment reviewed Mobilise as per physio / nursing review Falls Risk assessment score _____ appropriate strategy in place RIB (<i>TEDs / Leg ex</i>) SOOB Ambulate Passive full range of motion exercises for paralysed limbs Care of shoulder _____ Rest in bed Sit out of bed (<i>circle</i>)				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education of patient / family provided as per plan				Family Meeting:
Social work	Multidisciplinary family meeting required (<i>Circle</i>) Yes No				
Discharge Plan	Rehabilitation Health Care team discuss discharge plan Anticipated LOS: (<i>circle</i>) Short / Long Term If short-term MR 68 discharge plan completed If discharge early - Rankin Score: _____ PAC assessment completed				See assessment scale
ALL STAFF:	Please ensure Signature Register is completed				

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
	Date: _____ Day 5	AM	PM	ND	Comments
CNS	Conscious state assessed (<i>specify</i>) No deterioration in conscious state Patient is able to rest / sleep when appropriate Communication is unimpaired / impaired; verbal / nonverbal / absent				(<i>circle</i>)
CVS	TPR and BP q.i.d. (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				
Medications	Review by Pharmacist Medications given as per MR 10 Medications (<i>circle</i>); Oral, Nasogastric, PR, IV Education provided if appropriate				
Respiratory	No respiratory distress Nasopharyngeal suction required Yes / No				
GIT/Hydration	IV Site checked t.d.s. Site clean and dry IV removed if adequate hydration / no IV medications Fluids (<i>circle</i>): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (<i>circle</i>): Full, Soft, Minced, Vitamised, Nil orally				
Speech Path	Repeat Swallow assessment (Speech Path) if appropriate Nasogastric feeds: Type and Amount _____ Food / fluids tolerated FBC maintained Bowels open (<i>circle</i>) Continent Incontinent Consider aperient if BNO for 2 days				
Renal/Urinary	Urine (<i>circle</i>) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (<i>300 mL / shift</i>) Referral to continence nurse (all stroke patients) Reassess incontinence. Consider removal of IDC				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Risk assessed _____ P/Care _____ Specify aids needed (<i>as per strategy</i>) _____ Mouth and Eye care completed General Hygiene completed (<i>circle</i>); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment, Barthels / Hodkinsons				
Mobility	'No Lift' assessment reviewed Mobilise as per physio / nursing review Falls Risk assessment score _____ appropriate strategy in place RIB (TEDs / Leg ex) SOOB Ambulate Passive full range of motion exercises for paralysed limbs Gait and balance clinic referral considered if mobile Care of shoulder _____ Rest in bed Sit out of bed (<i>circle</i>)				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education of patient / family provided as per plan.				Family Meeting:
Social work	Multidisciplinary family meeting required, (<i>Circle</i>) Yes No				
Discharge Plan	Rehabilitation Health Care team discuss discharge plan Anticipated LOS: (<i>circle</i>) Short / Long Term If short-term MR 68 discharge plan completed Family meeting planned _____				
ALL STAFF:	Please ensure Signature Register is completed				

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
	Date: _____ Day 6	AM	PM	ND	Comments
CNS	Conscious state assessed (<i>specify</i>) No deterioration in conscious state Patient is able to rest / sleep when appropriate Communication is unimpaired / impaired; verbal / nonverbal / absent				(<i>circle</i>)
CVS	TPR and BP q.i.d. (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				
Medications	Review by Pharmacist Medications given as per MR 10 Medications (<i>circle</i>); Oral, Nasogastric, PR, IV Education provided if appropriate				
Respiratory	No respiratory distress Nasopharyngeal suction required Yes / No				
GIT/Hydration Speech Path	IV Site checked t.d.s.. Site clean and dry IV removed if adequate hydration / no IV medications Fluids (<i>circle</i>): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (<i>circle</i>): Full, Soft, Minced, Vitamised, Nil orally Repeat Swallow assessment (Speech Path) if appropriate Nasogastric feeds: Type and Amount _____ Food / fluids tolerated FBC maintained Bowels open (<i>circle</i>) Continent Incontinent Consider aperient if BNO for 2 days				
Renal/Urinary	Urine (<i>circle</i>) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (<i>300 mL / shift</i>) Reassess incontinence. Consider removal of IDC				
Continence Nr	Continence assessment completed, education provided				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Risk assessed _____ P/Care _____ Specify aids needed (<i>as per strategy</i>) _____ Mouth and Eye care completed General Hygiene completed (<i>circle</i>); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment, Barthels / Hodkinsons				
Mobility	'No Lift' assessment reviewed Mobilise as per physio / nursing review Falls Risk assessment score _____ appropriate strategy in place RIB (TEDs / Leg ex) SOOB Ambulate Passive full range of motion exercises for paralysed limbs Gait and balance clinic referral considered if mobile Care of shoulder _____ Rest in bed Sit out of bed (<i>circle</i>)				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education of patient / family provided as per plan.				
Social work	Multidisciplinary family meeting required, (<i>Circle</i>) Yes No				
Discharge Plan	Anticipated LOS: (<i>circle</i>) Short / Long Term If short-term MR 68 discharge plan completed Family meeting planned _____				
ALL STAFF:	Please ensure Signature Register is completed				

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label			
	Date: _____ Day: _____ Generic Day	AM	PM	ND	Comments
CNS	Conscious state assessed (<i>specify</i>) No deterioration in conscious state Patient is able to rest / sleep when appropriate Communication is unimpaired / impaired; verbal / nonverbal / absent				(circle)
CVS	TPR and BP q.i.d. (<i>Postural BP done b.d. if possible</i>) Patient afebrile and haemodynamically stable				
Medications	Review by Pharmacist Medications given as per MR 10 Medications (circle); Oral, Nasogastric, PR, IV Education provided if appropriate				
Respiratory	No respiratory distress Nasopharyngeal suction required Yes / No				
GIT/Hydration Speech Path	IV Site checked t.d.s.. Site clean and dry IV removed if adequate hydration / no IV medications Fluids (circle): Thin, Thick (Level 1 2 3 4), NG, Nil orally Diet (circle): Full, Soft, Minced, Vitamised, Nil orally Repeat Swallow assessment (Speech Path) if appropriate Nasogastric feeds: Type and Amount _____ Food / fluids tolerated FBC maintained Bowels open (circle) Continent Incontinent Consider aperient if BNO for 2 days				
Renal/Urinary	Urine (circle) - Continent Incontinent IDC / Condom Urinary output >30 mL / hour (<i>300 mL / shift</i>)				
Endocrine	BGL daily (<i>all patients</i>), q.i.d. if diabetic or elevated BGL < 10 mmol / L				
Skin Integrity/ Hygiene	Skin assessed to be in good condition Pressure Risk assessed _____ P/Care _____ Specify aids needed (<i>as per strategy</i>) _____ Mouth and Eye care completed General Hygiene completed (circle); Shower, Sponge Independent Partial assist Full assist				
Occupational T	OT assessment, Barthels / Hodkinsons				
Mobility	'No Lift' assessment reviewed Mobilise as per physio / nursing review Falls Risk assessment score _____ appropriate strategy in place RIB (TEDs / Leg ex) SOOB Ambulate Passive full range of motion exercises for paralysed limbs Gait and balance clinic referral considered if mobile Care of shoulder _____ Rest in bed Sit out of bed (circle)				Rehabilitation: Arrive: Depart:
Psychological / Education	Discuss plan of care as per patient pathway with patient / family Identify concerns / emotional status of patient Education of patient / family provided as per plan.				
Discharge Plan	MR 68 discharge plan completed prn Refer to A & D Coordinator if applicable Family meeting planned _____				
ALL STAFF: Please ensure Signature Register is completed					

STROKE / T.I.A. CLINICAL PATHWAY WIMMERA HEALTH CARE GROUP		Pt. ID Label		
Use Generic Day, if not being discharged				
RMO History Exam	initial	Date: _____ Day: _____ Discharge Day _____ Discharge Time: _____		
		No evidence of DVT / PE Chest clear / no deterioration Review results of ordered tests: Blood pressure controlled Ready for discharge / transfer (circle)		
Management		Reinforce plan with patient / carer Discharge drugs ordered Patient aware of driving restrictions for 1 months post stroke (then reassessment)		
		RMO NOTES continued over page		
		AM	PM	Comments
CNS				Patient alert and able to communicate
				Modified Rankin Score completed. (Assessment scale back 1 page) Score: _____
				Patient is able to rest / sleep when appropriate
				Patient comfortable, no pain relief required
CVS				Patient afebrile and haemodynamically stable
Medications				Discharge medications provided and discussed
				Patient / carer understands medication regime
Respiratory				No respiratory distress
GIT/Hydration				Patient is tolerating normal diet and fluids
				Patient has regular bowel habit
				Nasogastric / PEG feeding established
Renal				Urinary continence managed
Skin Integrity/ Hygiene				Skin remains intact
Occupational Therapy				Patient / carer demonstrates ability to manage ADLs
				Home situation suitable for discharge
				Equipment supplied
				Patient aware of driving restrictions
				Occupational Therapy appointment arranged: _____
Mobility				Patient demonstrates ability to mobilize safely
				Physiotherapy appointment arranged: _____
				Gait aid hired
Psychological / Education				Patient/carer expresses understanding of disease process and management plan.
				Patient's emotional state is stable
Discharge Planning (achieved prior to Discharge)				Medical review completed, patient 'ready for discharge'
				Self management plan (discharge plan) completed
				Patient / carer verbalises plans and appointments
				Social Work follow-up: _____
				Community support services in place if applicable
				Has discharge medications
				Patient is comfortable with ADLs and support services
				Community Rehabilitation Centre appointment made
				Patient is confident / satisfied with discharge plan
			Patient discharged home at _____ (hours)	
PLEASE ENSURE 1 PAGE PATHWAY AUDIT IS COMPLETED				
Date/Time	Progress Notes/Variance (V black circled) with reason if known, followed by Action/Treatment/Outcome, sign entry			
Please ensure Signature Register is completed				

