Bloomington Hospital
Bloomington, Indiana

Neuroscience Services

ISCHEMIC, HEMORRHAGIC STROKE CLINICAL PATHWAY

Critical Elements & Status	Day of Stroke Date ________	Completed	Day One After Stroke Date ________	Completed
Neurological Maintain optimal neurological function	1. Neurological assessment every 1 hour (CC) or 4 hours or as ordered	☐7a –7p ☐7p –7a	1. Neurological assessment every 1 hour (CC) or 4 hours or as ordered	☐7a –7p ☐7p –7a
	2. Elevate HOB ≥ 30°	☐7a –7p ☐7p –7a ☐N/A ☐N/A	2. Elevate HOB ≥ 30°	☐7a –7p ☐7p –7a ☐N/A ☐N/A
	3. Notify physician of any decline in Neuro status	☐Yes ☐N/A	3. Notify physician of any decline in Neuro status	☐Yes ☐N/A
	4. Monitor for seizure activity and notify physician for new onset of seizures	☐7a –7p ☐7p –7a	4. Monitor for seizure activity and notify physician for new onset of seizures	☐7a –7p ☐7p –7a
	5. Initiate seizure precautions as needed	☐7a –7p ☐7p –7a ☐N/A ☐N/A	5. Initiate seizure precautions as needed	☐7a –7p ☐7p –7a ☐N/A ☐N/A
	6. **For hemorrhagic stroke**: administer prophylactic seizure medications as ordered	☐7a –7p ☐7p –7a	6. **For hemorrhagic stroke**: administer prophylactic seizure medications as ordered	☐7a –7p ☐7p –7a
Psychosocial Maximize support/understanding of disease process & rehabilitation	1.Give educational material (stroke education packet)	☐Yes ☐Needs completed	1. Update family & provide emotional support as needed	☐Yes ☐Needs completed
	2. Social Service Consult	☐Yes ☐Needs completed	2. Begin discharge planning	☐Yes ☐Needs completed
	3. Monitor for depression	☐7a –7p ☐7p –7a	3. Monitor for depression	☐7a –7p ☐7p –7a
Nutrition/Hydration Maintain adequate nutrition and hydration for maximal health	1. NPO until swallowing evaluation to prevent aspiration	☐Yes ☐No ☐N/A If no, comment _________	1. SLP evaluation	☐Yes ☐No ☐N/A
			2. Implementation of diet	☐Yes ☐No ☐N/A
	2. IVF/ hep well	☐7a –7p ☐7p –7a	3. Nutritional consult prn	☐Yes ☐No ☐N/A
	3. Monitor diabetes and/or notify physician of elevated blood glucose >200	☐7a –7p ☐7p –7a ☐N/A ☐N/A	4. Diabetes Ed consult prn	☐Yes ☐No ☐N/A
			5. Maintain IVF/ hep well	☐Yes ☐No ☐N/A
			6. Oral care	☐Yes ☐No ☐N/A
			7. Frazier Water Protocol	☐Yes ☐No ☐N/A
			8. Monitor diabetes and/or notify physician of elevated blood glucose >200	☐Yes ☐No ☐N/A
Ventilation Maintain adequate oxygenation (aspiration risk especially first 48 hours)	1. Assess breath sounds every shift & prn	☐7a –7p ☐7p –7a	1. Assess breath sounds every shift & prn	☐7a –7p ☐7p –7a
	2. Pulse Oximetry per protocol	☐7a –7p ☐7p –7a	2. Pulse Oximetry per protocol	☐7a –7p ☐7p –7a
	3. Assess for signs and symptoms of aspiration or pneumonia, notify physician of abnormal findings	☐7a –7p ☐7p –7a	3. Assess for signs and symptoms of aspiration or pneumonia, notify physician of abnormal findings	☐7a –7p ☐7p –7a

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Patient-Last Name, First Name, Middle Initial Age

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Admission Number Date Birth Date

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Physician Name

Patient Identification ___________________ Medical Record Number

	Initials	Signature	Date	Time
7a-7p	_____	___________________________	________	________
7p-7a	_____	___________________________	________	________
7a-7p	_____	___________________________	________	________
7p-7a	_____	___________________________	________	________

Critical Elements & Status	Day of Stroke Date ________	Completed	Day One After Stroke Date ________	Completed
Circulation/Bleeding Maintain adequate circulation to promote cerebral perfusion Provide DVT prophylaxis ie; SCD's Lovenox, Heparin *SCDs are on and documented*	1. Monitor VS every 1 or 4 hours or as ordered 2. Maintain SBP <_______, >_______ , DPB <_______, >_______ as ordered 3. Monitor ordered coagulation labs 4. Assess for signs and symptoms of bleeding 5. Avoid invasive procedures for 24 hours after Thrombolytic therapy 6. DVT prophylaxis 7. Telemetry	☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a	1. Monitor VS every 1 or 4 hours or as ordered 2. Maintain SBP <_______, >_______ , DPB <_______, >_______ as ordered 3. Monitor ordered coagulation labs 4. Assess for signs and symptoms of bleeding 5. Avoid invasive procedures for 24 hours after Thrombolytic therapy 6. Restart home anti-hypertensive & a-fib medications as ordered 7. Lipid profile result on chart 8. **Ischemic stroke** start/ restart statins as ordered 9. DVT prophylaxis 10.Telemtry	☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a
Elimination Maintain optimal kidney & bowel function	1. I & O 2. Notify physician if no BM for 3 days 3. Assess for signs and symptoms of UTI, retention notify physician of abnormal findings	☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐7a –7p ☐7p –7a ☐N/A	1. I & O 2. Administer stool softeners and laxatives as ordered 3. Notify physician if no BM for 3 days 4. Assess for signs and symptoms of UTI, retention notify physician of abnormal findings. 5. Assist to BSC/BR for elimination, if able	☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐7a –7p ☐7p –7a ☐Yes ☐No ☐N/A
Pain/Rest Promote adequate pain relief to maintain patient comfort	1. Assess for pain & offer pain med as ordered 2. Assess sleep patterns	☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a	1. Assess for pain & offer pain med as ordered 2. Assess sleep patterns	☐7a –7p ☐7p –7a ☐7a –7p ☐7p –7a
Skin Integrity Prevent skin breakdown	1. Turn & reposition every 2 hours prn 2. Skin assessment per policy	☐7a –7p ☐7p –7a ☐N/A ☐7a –7p ☐7p –7a	1. Turn & reposition every 2 hours prn 2. Skin assessment per policy	☐7a –7p ☐7p –7a ☐N/A ☐7a –7p ☐7p –7a

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Patient-Last Name, First Name, Middle Initial Age

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Admission Number Date Birth Date

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Physician Name

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Patient Identification Medical Record Number

	Initials	Signature	Date	Time
7a-7p	_____	___________________________	________	________
7p-7a	_____	___________________________	________	________
7a-7p	_____	___________________________	________	________
7p-7a	_____	___________________________	________	________

Critical Elements & Status	Day of Stroke Date ________	Completed	Day One After Stroke Date ________	Completed
Activity/Mobility Prevent contractures. Maximize functional abilities (May be completed by OT, PT & Nursing)	1. Turn and reposition 2. OT/PT consult 3. Maintain HOB 4. Advance mobility as tolerated	☐7a –7p ☐7p –7a ☐N/A ☐Yes ☐No ☐N/A ☐Flat ☐≥30° ☐≥45° ☐N/A ☐Yes ☐No ☐ N/A	1. Turn and reposition 2. OT/PT consult 3. Maintain HOB 4. Advance mobility as tolerated	☐7a –7p ☐7p –7a ☐N/A ☐Yes ☐No ☐N/A ☐Flat ☐≥30° ☐≥45° ☐N/A ☐Yes ☐No ☐ N/A
Education Maximize patient/family/caregiver understanding of stroke risk factors, signs and symptoms EMS activation	1. Provide stroke education Material 2. Review personal risk factors (check all that apply) 3. Provide smoking cessation Information (RT or Nursing) 4. Provide information regarding stroke signs and symptoms and EMS activation.	☐Yes ☐Needs completed ☐Previous stroke/TIA ☐Smoking ☐Alcohol use ☐Hypertension ☐Diabetes ☐A-Fib ☐Hyperlipidemia LDL _____ ☐Yes ☐No ☐ N/A ☐Yes ☐ Needs completed	1. Assess for additional learning needs regarding stroke education	☐Yes ☐ N/A Additional education provided for the following: ☐Previous stroke/TIA ☐Smoking ☐Alcohol use ☐Hypertension ☐Diabetes ☐A-Fib ☐Hyperlipidemia LDL_____ ☐Smoking Cessation ☐Stroke signs and symptoms ☐EMS Activation ☐________________

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Patient-Last Name, First Name, Middle Initial Age

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Admission Number Date Birth Date

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Physician Name

Patient Identification __________________
Medical Record Number

	Initials	Signature	Date	Time
7a-7p	_____	___________________________	________	________
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7a-7p	_____	___________________________	________	________
7p-7a	_____	___________________________	________	________

Critical Elements & Status		Day Two After Stroke Date _________	Day Three After Stroke Date ________	Day Four After Stroke Date ________
Neurological Maintain optimal neurological function	1. Neurological assessment every 1 or every 4 hours as ordered	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	2. Elevate HOB ≥30°	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A
	3. Notify physician of any decline in Neuro status	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	4. Monitor for seizure activity and notify MD for new onset of seizures	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	5. Initiate seizure precautions as needed	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	6. ***For hemorrhagic stroke:*** administer prophylactic seizure medications as ordered	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A
Psychosocial Maximize support/understanding of disease process & rehabilitation (To be completed by Social Services)	1. Update family & provide emotional support as needed	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	2. Monitor for depression	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	3. Continue discharge planning	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	Discharge to: ☐Home ☐ECF ☐Rehab ☐Home Health Care ☐N/A
Nutrition/Hydration Maintain adequate nutrition for maximal health	1. Dysphagia evaluation	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	2. Implementation of diet	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	3. Maintain IVF or HW	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	4. Oral care	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	5. Frazier Water Protocol	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	6. Tube feeding	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	7. Nutritional consult and Diabetes Ed if not done	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	8. Monitor diabetes and/or notify physician of elevated blood glucose >200	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
Ventilation Maintain adequate oxygenation	1. Assess breath sounds every shift & prn	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	2. Pulse Oximetry per protocol	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	3. Assess for signs and symptoms of aspiration and pneumonia, notify physician of abnormal findings	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a

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Patient-Last Name, First Name, Middle Initial   Age

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Admission Number   Date   Birth Date

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Physician Name

Patient Identification   ________________ Medical Record Number

	Initials	Signature	Date	Time
7a-7p	_____	______________________	________	________
7p-7a	_____	______________________	________	________
7a-7p	_____	______________________	________	________
7p-7a	_____	______________________	________	________

Critical Elements & Status		Day Two After Stroke Date_________	Day Three After Stroke Date ________	Day Four After Stroke Date ________
Circulation/Bleeding Maintain adequate circulation to promote cerebral perfusion Provide DVT prophylaxis ie; SCD's Lovenox, Heparin. *SCDs are on and documented*	1. Monitor VS every 1 hour (CC) or every 4 hours as ordered	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	2. Maintain SBP <_______, >_______ , DPB <_______, >_______ as ordered	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	3. Monitor coagulation labs as ordered	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	4. Assess for signs and symptoms of bleeding	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	5. Restart home anti-hypertensive & a-fib medications as ordered	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	6. Lipid profile result on chart	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	7. **Ischemic stroke** start/ restart statins as ordered	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	8. Physician to assess need continue Telemetry	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	9. DVT prophylaxis	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
Elimination Maintain optimal kidney & bowel function	1. I & O	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	2. Administer stool softeners and laxatives as ordered	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	3. Notify physician if no BM for 3 days	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	4. Assess for signs and symptoms of UTI, retention notify physician of abnormal findings	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	5. Assist to BSC/BR for elimination, if able	☐Yes ☐N/A	☐Yes ☐N/A	☐Yes ☐N/A
	6. Discontinue indwelling catheter	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Pain/Rest Promote adequate pain relief to maintain patient comfort	1. Assess for pain/discomfort & offer pain med as ordered	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
Skin Integrity Prevent skin breakdown	1. Turn & reposition every 2 hours prn	☐7a –7p ☐7p –7a ☐ N/A ☐N/A	☐7a –7p ☐7p –7a ☐ N/A ☐N/A	☐7a –7p ☐7p –7a ☐ N/A ☐N/A
	2. Skin assessment per policy	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a

	Initials	Signature	Date	Time
7a-7p	_____	______________________________	________	________
7p-7a	_____	______________________________	________	________
7a-7p	_____	______________________________	________	________
7p-7a	_____	______________________________	________	________

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Patient-Last Name, First Name, Middle Initial   Age

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Admission Number   Date   Birth Date

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Physician Name

Patient Identification   ________________
Medical Record Number

Critical Elements & Status		Day Two After Stroke Date _________	Day Three After Stroke Date ________	Day Four After Stroke Date ________
Activity/Mobility Prevent contractures. Maximize functional abilities (May be completed by OT, PT & Nursing)	1. ROM twice daily	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	2. Transfer to chair twice daily, if able	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a	☐7a –7p ☐7p –7a
	3. Turn and reposition Q2hr and PRN	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A	☐7a –7p ☐7p –7a ☐N/A ☐N/A
	4. Educate family/staff on care activities	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
	5. Address equipment needs See therapy notes ICP	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Education Maximize patient/family understanding of stroke risk factors	1. Assess for additional learning needs regarding stroke education and provide additional information as needed	☐Yes ☐N/A Additional education provided for the following: ☐Previous stroke/TIA ☐Smoking ☐Alcohol use ☐Hypertension ☐Diabetes ☐A-Fib ☐Hyperlipidemia LDL_____ ☐ Smoking Cessation ☐ Stroke signs and symptoms ☐ EMS Activation ☐ ____________	☐Yes ☐N/A Additional education provided for the following: ☐Previous stroke/TIA ☐Smoking ☐Alcohol use ☐Hypertension ☐Diabetes ☐A-Fib ☐Hyperlipidemia LDL_____ ☐ Smoking Cessation ☐ Stroke signs and symptoms ☐ EMS Activation ☐ ____________	☐Yes ☐N/A Additional education provided for the following: ☐Previous stroke/TIA ☐Smoking ☐Alcohol use ☐Hypertension ☐Diabetes ☐A-Fib ☐Hyperlipidemia LDL_____ ☐ Smoking Cessation ☐ Stroke signs and symptoms ☐ EMS Activation ☐ ____________

Day of Discharge **Date**___________	1. Discharge instructions/ stroke education completed	☐Yes ☐No	**Comments** ____________	
	2. Prescription for BP medicine	☐Yes ☐No ☐N/A		
	3. Prescription for Statin	☐Yes ☐No ☐N/A		
	4. Prescription for Antithrombotic (ASA, Plavix, Aggrenox	☐Yes ☐No ☐N/A		
	5. Patient with A-Fib is on Warfarin (Coumadin)	☐Yes ☐No ☐N/A		
	6.Transfer to ARU or ECF	☐Yes ☐N/A		
	7. Medications and follow-up appointments reviewed	☐Yes		

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Patient-Last Name, First Name, Middle Initial Age

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Admission Number Date Birth Date

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Physician Name

Patient Identification ________________
Medical Record Number

	Initials	Signature	Date	Time
7a-7p	_____	_______________________	________	________
7p-7a	_____	_______________________	________	________
7a-7p	_____	_______________________	________	________
7p-7a	_____	_______________________	________	________