<table>
<thead>
<tr>
<th>Admission Day</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 0-1 (1st 24hrs) &gt; ED to Stroke Unit</td>
<td>Acute Stroke Unit</td>
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</tr>
<tr>
<td>Goals/Outcomes</td>
<td>Neuro status stabilised / improving / deteriorating</td>
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</tr>
<tr>
<td>Pathology/Diagnostic Tests</td>
<td>Avoid complications - aspiration, infection, DVT / PE, falls</td>
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</tr>
<tr>
<td>Treatment</td>
<td>Initial diagnostic test results documented.</td>
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</tr>
<tr>
<td>Nursing Care</td>
<td>rehab therapies initiated / continued / Rehab goals set / documented</td>
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</tr>
<tr>
<td>Nutritional/ Hydration</td>
<td>Pathology / Evaluations &amp; Management</td>
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</tr>
<tr>
<td>Activity</td>
<td>Pathology / Pathway Consideration</td>
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</tr>
<tr>
<td>Referrals / Consults</td>
<td>BSL 5-10mmol/L &gt; q6h; BSL: &gt; 10mmol/L -&gt; Insulin infusion</td>
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<tr>
<td>Patient / Family Education</td>
<td>rehab therapies continued as appropriate.</td>
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<tr>
<td>Discharge Planning</td>
<td>Pathology / Pathway Consideration</td>
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</table>

**Admission Day**

- Identify acute ischaemic / haemorrhagic / TIA / others…
- Document time and date of symptoms onset
- Scandinavian Stroke Scale
- Swallowing screening / Safe swallowing

**Pathology / Diagnostic Tests**

- Brain CT scan without contrast
- FBC / PT / APTT / INR, ESR, EUC, LFT, BSL
- ECG / CXR / UA
- Consider: MRI / CTA / TOE / TTE / Carotid Doppler

**Treatment**

- IV - N/S if NBM or dehydrated
- BP management as per Consultant / medication ordered
- Fever ≥37.5°C, Paracetamol: ≥38°C -> septic work-up
- BSL ≤ 10mmol/L: q6h; BSL > 10mmol/L: Insulin infusion
- Evaluate prior medications / Continue pre-existing meds
- Bowel regime
- Antipettelet / oral / PR
- Consider: Anticoagulation / Consultant decision

**Nursing Care**

- Neuro obs and vital signs q4h, (or as per protocol if thrombolysed)
- Stroke telemetry – BP, HR, T, SaO2, cardiac rhythm
- BSL q4h -> before meals & bedtime
- Bowel / Bladder assessment & management
- IV fluids: NS Only +/– K+.
- Nutritional support via fine bore NG
- Consider: Fine bore NG for medication & early nutrition

**Nutritional / Hydration**

- Advance diet as per Speech Pathologist or NBM if dysphagia / Safe swallowing precautions
- Fine bore NG tube and feeds, goal rate set
- Electric stimulation if appropriate

**Activity**

- Functional assessment, encourage participation in functional activities.
- Increase activity / exercises of hemiparetic limbs, as per Physio and OT assessment
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**Referrals / Consults**

- Stroke CNC
- Physiotherapist
- Occupational Therapist
- Speech Pathologist
- Pharmacist
- Consider: Cardiology / Neurosurgery / Endocrinology

**Patient / Family Education**

- Orientate to stroke unit
- Education about tests / monitoring / planned care
- Education about stroke risk factors and complications

**Discharge Planning**

- Evaluation of pre-existing function and home environment
- Case discussion and planning at multidisciplinary meeting
- Ongoing stroke education
- Rehabilitation waiting list as appropriate
- Case discussion and planning at multidisciplinary meeting
- TIA patient may be discharged as appropriate

**Consider:** Repeat CT (if stroke not yet confirmed)
### Acute Stroke & Transient Ischaemic Attack
#### Clinical Pathway / Blacktown Hospital @WSLHD

**Patient’ Name** ___________  **MRN** ___________

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<tr>
<th>Goals/ Outcomes</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6 or Discharge Day</th>
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<tr>
<td></td>
<td>Acute Stroke Unit</td>
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<td>Step Down from Stroke Unit</td>
</tr>
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<td>Avoid complications</td>
<td></td>
<td></td>
<td>Complications avoided</td>
</tr>
<tr>
<td>Rehabilitation therapies continued as appropriate.</td>
<td></td>
<td></td>
<td>Aware of signs and symptoms of stroke</td>
</tr>
<tr>
<td>Patient / Family understands stroke causation &amp; risk factors</td>
<td></td>
<td></td>
<td>Follow up post discharge organised.</td>
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<tr>
<td>APTT daily if therapeutic on heparin</td>
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**Pathology/ Diagnostic Tests**

- APTT daily if therapeutic on heparin
- INR daily if on Warfarin
- Follow up abnormal test results

**Treatment**

- IV if required  – N/S Only +/- electrolytes
- Medication review
- Diabetes management plan
- Antiplatelets / anticoagulation long-term planning

**Nursing care**

- Neuro obs and vital signs q4h
- Bowel / Bladder assessment / training
- Avoid indwelling catheter / Post voiding scanning
- HOB up 30° / Safe swallowing precautions
- BSL daily or q6h if > 10mmol
- Turn q4h or prn if patient mobility restricted
- Positioning of hemiparetic limbs / Protect & Support
- Pressure area risk / Falls Risk assessment / addressed
- Assess NG tube patency / positioning q4h

**Nutrition / Hydration**

- Diet advanced / maintained as per Speech Pathologist recommendation
- Continue nutrition requirements as per Dietitian
- Maintain NG tube feeds at goal rate.

**Activity**

- Encourage independence and participation in functional activities
- Increase activity / exercises of hemiparetic limbs as per Physio and OT assessment

**Rehabilitation Consults**

- Rehabilitation inpatient / outpatient
- Stroke Outreach Service

**Patient/Family Education**

- Reinforce stroke risk factors education
- Medication education, eg. Warfarin, antplatelet agents
- Discuss / finalise plans for rehabilitation / discharge

**Discharge Planning**

- Confirm discharge plan
- Inpatient Rehabilitation / Outpatient Rehabilitation
- Placement in Nursing Home / Hostel
- Home + Community Support
- Informal - family
- Formal - Specifying
- Home independent
- Transfer to other wards; eg. AGU / Med / CSDU / TCU

**Pathologist recommendation**

- Consider: Long term feeding options
- Castro review
- OT home visit

**Follow up arrangements by Allied Health**

- Rehabilitation
- Home health care
- Home nursing

**Follow up arrangements by Allied Health**

- Follow up arrangements by Allied Health

**Secondary Stroke Prevention**

- Anticoagulation / antiplatelet plan
- Lifestyle changes; eg smoking cessation, ETOH, weight ↓
- Diabetes
- Hyperlipidemia

**Reinforce Secondary Stroke Prevention**

- BP management
- Diabetes
- Hyperlipidemia

**Vitals as required**

- Bowel / Bladder assessment / training
- HOB up 30° / Safe swallowing precautions
- BSL daily or q6h if > 10mmol
- Turn q4h or prn if patient mobility restricted
- Positioning of hemiparetic limbs / Protect & Support
- Pressure area risk / Falls Risk assessment / addressed
- Assess NG tube patency / positioning q4h

**Reinforce Anticoagulation / antiplatelet plan**

- Lifestyle changes; eg smoking cessation, ETOH, weight ↓
- Diabetes
- Hyperlipidemia

**Review medication prior to discharge**

- Lifestyle changes; eg smoking cessation, ETOH, weight ↓
- Diabetes
- Hyperlipidemia

**Discharge as appropriate**

- Reinforce medication management plans
- Reinforce lifestyle adaptation
- Reinforce medication management plans
- Rehabilitation goals & needs
- Contact details for support and follow up given

**Review post discharge organised.**

- Reinforce medication management plans
- Rehabilitation goals & needs
- Contact details for support and follow up given

**Aware of signs and symptoms of stroke**

- Follow up post discharge organised.

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