

CARE GUIDELINES FOR ISCHEMIC STROKE PATIENTS ADMITTED TO THE ACUTE STROKE UNIT
THIS IS A CHECKLIST TO GUIDE PROVIDERS IN PLACING THE CORRECT ORDERS
ORDERS MUST STILL BE ENTERED USING THE ORDER SET IN EPIC

Use this Order Set: Ischemic Stroke/TIA Stepdown Admission

- Stepdown admission with Telemetry (**NOT GPU**)
- Continuous cardiac monitoring
- Vital signs Q2h
- Neuro checks Q2h
- Bedrest, then advance activity orders when appropriate, for PT/OT evaluations.
- NPO until Dysphagia Screen completed:
 - Patient fails Dysphagia Screen: make the patient NPO, order SLP consult for Dysphagia.
 - Patient passes Dysphagia Screen: order appropriate diet.
- Place an order for neurology to consult and manage.
- Order PT/OT/SLP/Nutrition consults.
- Labs: Electrolytes, Magnesium, Phosphorous, PT/INR/PTT.
- Lipid panel and Hemoglobin A1C must be completed within 48 hours of hospital arrival.
- MRI of the brain and MRA of the head and neck without contrast.
- 12 Lead EKG and Chest x-ray if not completed in the ED.
- Echocardiogram
- Other diagnostic testing to identify the cause of stroke (neurology to make recommendations).
- Medications:
 - a. Avoid narcotic pain medications and other sedating medications if possible.
 - b. Defer to neurology re: anticoagulant management for AFib/Flutter.
 - c. IV fluids, acetaminophen, stool softeners, laxatives, antacids, nicotine replacement therapy.
 - d. Antithrombotic therapy: typically ASA (order rectal if NPO) or Plavix.
*Administration of antithrombotic therapy must be documented by the end of hospital day 2 or document a specific reason for contraindication.
 - e. Statins: Patients with an LDL>100 should have statin therapy initiated and be discharged on a statin. If statin therapy is contraindicated, document the specific reason why. *Only statins count for the core measure.
 - f. ICU Glycemic Protocol
 - g. ICU Electrolyte Protocols for Potassium, Magnesium, Phosphate
- Blood pressure management:
 - a. Acute phase of stroke: home BP meds are typically held, with the exception of medications for rate control.
 - b. Each patient is different in terms of BP parameters. We don't generally treat unless SBP>220 and/or DBP>110. May order IV Labetolol or IV Hydralazine prn.
 - c. Defer to neurology for any questions re: BP control and restarting home BP meds.
- VTE Prophylaxis: SQ Heparin or Lovenox
SCD's
*Administration of VTE prophylaxis must be documented by the end of hospital day 2.
- Bowel protocol

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Core measures:

- Anticoagulation must be addressed for patients with any history of AFib/Flutter (including post-ablation and paroxysmal). * If anticoagulation is contraindicated the documentation must specifically state why.
- NIHSS completed within 48 hours of hospital admission, daily, and at the time of discharge.
- mRS (Modified Rankin Scale) completed at discharge.
- Ischemic stroke patients should have a follow-up appointment in the WBH stroke clinic, typically with Dr. Hefzy, within 1-2 weeks of discharge. This should be scheduled before they are discharged. The neurology MLP's have been scheduling this, however, in the event that they do not, here is the process:
 - Weekdays: email Maureen Foley (Dr. Hefzy's secretary) with the patient's name and MRN. She will schedule the appointment and put it in EPIC. Please let the patient know when their follow-up appointment is and include it on their AVS.
 - Weekends: email Maureen with the patient's name and MRN. Maureen will contact the patient with the date/time when she makes the appointment.
- Patients admitted to the ICU for stroke who are ready to be transferred out of the unit should be admitted to the Acute Stroke Unit under Stepdown status.