Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Admission

This is a general guideline and does not represent a professional care standard governing provider obligations to patients.
Care is revised to meet individual patient needs.

I. Admit To: Service	**Unit/Ward:**	**Change of Service/Team as of:**
MD/NP/PA:	**Pager No.: ( )**	______ /______ /_______ **Time:** _______________
MD/NP/PA:	**Pager No.: ( )**	
Sr. Resident:	**Pager No.: ( )**	**To:**____
Attending M.D.:	**Pager No.: ( )**	

Instructions: All patients will be placed on this clinical pathway unless excluded for one or more of the following reasons:

II. Inclusion Criteria:

No exclusions, place on pathway for:
- ☐ Non-hemorrhagic stroke

III. Excluded for:
- ☐ Pregnancy of greater than 16 weeks gestation
- ☐ Hemorrhagic stroke
- ☐ Use of tPA in emergency department
- ☐ Patient admitted with severe, complicating medical diagnosis
- ☐ Less than 30 years of age

IV. Diagnosis: Acute ischemic stroke (NIH Stroke Scale score _____________)

V. Clinically Significant Co-Morbidity(s): ☐ None

- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ History of cardiac arrhythmia
- ☐ Atrial fibrillation
- ☐ Hypertension
- ☐ Pulmonary disease
- ☐ Renal disease (creatinine greater than 2.5 mg per dL)
- ☐ _____________________
- ☐ Diabetes
- ☐ Cancer
- ☐ Morbid obesity (BMI 40 or greater)
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Homelessness
- ☐ _____________________

VI. Allergies:

☐ Known allergies (specify) ☐ No known allergies

a. ____

b. ____

c. ____

VII. Height/Weight: (To be completed by RN) **Height: ________cm or ________in** **Weight: ________kg or ________lb**

VIII. Condition: ☐ **Good** ☐ **Fair** ☐ **Serious** ☐ **Critical**

CPR Status and Patient Directives

A. CPR status order: All patients are "Full Code" unless one of the following DNR boxes is selected:
- ☐ **DNR: Do not start CPR -** *Continue all other medical/surgical management unless excluded in section [B] below*
- ☐ **DNR: Do not start CPR -** *Patient is terminally ill and requests comfort measures (pain and symptom management) only*

B. Patient directives during this hospitalization:
- ☐ No intubation
- ☐ No invasive procedures
- ☐ No blood draws
- ☐ No pressors
- ☐ No blood products
- ☐ No dialysis
- ☐ No antibiotics
- ☐ Other: ____________________________

Attending Physician Sig: _________________________________ ID#: ___________ Date: ____ /____ /_____ Time: ____________

These orders require concurrent attending approval documented in the progress notes with attending' s signature of order within 24 hrs.

Provider Last Name (Print):	
Provider Signature:	ID#:
Date: / /	Time: : AM / PM
RN Last Name (Print):	
RN Signature:	Initials:
Date: / /	Time: : AM / PM
Clerk/LVN Signature:	Initials:
Date: / /	Time: : AM / PM

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Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Day 1 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please"X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

- ☑ Vital signs Q4 hrs X 24 hrs then Q8 hrs
- ☑ Pulse oximetry: ☐ Continuous ☐ Q8 hrs ☐ Q12 hrs
- ☑ Record strict input and output Q8 hrs
- ☑ Neuro checks Q4 hrs X 24 hrs then Q8 hrs
- ☑ Obtain old chart
- ☐ Weigh patient daily
- ☐ Cardiac monitor (telemetry monitoring) X 24 hrs

Physician Notification: ***Notify provider for any of the following:***

- ☑ Systolic BP less than ______ or greater than ______ mm Hg
- ☑ Diastolic BP less than ______ or greater than ______ mm Hg
- ☑ Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F)
- ☑ O2 saturation less than 94% with or without O2 administered
- ☑ Blood glucose greater than 175 mg per dL
- ☑ Pulse less than 55 or greater than 100 BPM
- ☑ Resp. rate less than 12 or greater than 30
- ☑ Change in neurological status
- ☑ Increased agitation
- ☑ Urinary output: less than 240 mL within 8 hrs

Activity:

- ☐ Bed rest
- ☐ Soft restraints for agitation - see separate restraint order sheet
- ☐ Up in chair at least TID (with assistance as needed)
- ☐ Other:
- ☐ Head of bed up 30º
- ☐ Ambulate in hallway at least TID (with assistance as needed)
- ☐ Range of motion upper and lower extremities 5 times each TID

Diet: **High risk patients (those with brainstem or bulbar infarcts, or poor phonation) require a formal swallow study. Other patients may be evaluated with a bedside swallow study (sit patient up straight, offer sips of water and observe for signs of aspiration). Document results in progress note.**

- ☐ NPO except medications
- ☐ NPO until formal swallow evaluation completed by PT, OT, or speech therapy
- ☐ Call MD when formal swallow evaluation complete
- ☐ Consistent Carbohydrate (ADA)
- ☐ Heart Healthy (low fat, low cholesterol)
- ☐ Other:

Treatment:

- ☐ Straight cath if unable to void within 6 hrs
- ☐ Aspiration precautions
- ☐ Fall precautions
- ☐ O2 via nasal cannula at 1-5L per min to maintain O2 sat greater than 94%
- ☐ Foley catheter to gravity
- ☐ IV ____________________at_______mL per hr
- ☐ Insert saline lock, flush per Unit protocol
- ☐ Turn Q2 hrs

Consults:

- ☐ Neurology:
- ☐ Cardiology:
- ☐ Nutrition:
- ☐ Swallow evaluation:
- ☐ Speech therapy:
- ☐ Other:
- ☐ Physical therapy:
- ☐ Physical therapy for rehabilitation evaluation
- ☐ Rancho Los Amigos rehabilitation evaluation
- ☐ Occupational therapy:
- ☐ Respiratory therapy:

Provider Last Name (Print):	
Provider Signature:	ID#:
Date: / /	Time: : AM / PM
RN Last Name (Print):	
RN Signature:	Initials:
Date: / /	Time: : AM / PM
Clerk/LVN Signature:	Initials:
Date: / /	Time: : AM / PM

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Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Day 1 of 5

Medication Reconciliation: List all patient's home medications (include samples, OTC, vitamins, herbals, and others); Select Continue or Discontinue. **Do not duplicate orders written here in the next medication order sections.** (Prohibited abbreviations: qd, qod, U, IU, lack of leading zero .X, trailing zero X.0, MS, MSO4, MgSO4)

Information source:______________________________ ☐ Patient not currently taking medication ☐ Medication history not available

☐ NKDA ☐ Allergies/specify reactions:____ ☐ Pregnant ☐ Breastfeeding

Weight:________kg_______lbs ☐ Measured ☐ Stated Height:______ cm ____ ft ____ in

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			

M.D. Signature: ______________________ ID#: __________

Date: ______________ Time: ______________

R.N. Signature: ______________________ Init: __________

Date: ______________ Time: ______________

Clerk Signature: ______________________ Init: __________

Date: ______________ Time: ______________

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Day 1

Medicine DVT Risk Assessment Tool

Contraindications to Anticoagulation
(consider sequential compression device alone if anticoagulation is contraindicated)

Absolute
- ☐ Active hemorrhage
- ☐ History of heparin induced thrombocytopenia (HIT)
- ☐ Current severe hypertension (BP ≥190/110)

Relative
- ☐ Active intracranial lesion/neoplasm
- ☐ Biopsy sites inaccessible to hemostatic control
- ☐ GI or GU bleed within past 4 weeks
- ☐ Previous cerebral hemorrhage
- ☐ Proliferative retinopathy
- ☐ Recent intraocular or intracranial surgery
- ☐ Thrombocytopenia or other coagulopathy
- ☐ Traumatic or repeated epidural or spinal puncture

Relative Contraindications to Sequential Compression Device
- ☐ Acute superficial or deep vein thrombosis
- ☐ CHF (class III or IV)
- ☐ Severe peripheral artery disease

Risk Factors
(1 point each unless otherwise noted)

Stasis
- ☐ Acute COPD exacerbation
- ☐ Acute MI
- ☐ Age 40 years or greater
- ☐ Anticipated immobilization/bed confinement (greater than 24 hrs)
- ☐ CHF (class III or IV) **(3 points)**
- ☐ Leg swelling, ulcers or varicose veins
- ☐ Mechanical ventilation **(3 points)**
- ☐ Obesity (BMI 30 or greater)
- ☐ Patient hospitalized, in SNF or nursing home within 90 days **(3 points)**
- ☐ Pneumonia
- ☐ Recent confining travel (air or ground) greater than 4 hrs
- ☐ Spinal cord injury with paresis **(3 points)**
- ☐ Stroke with paresis **(3 points)**

Hypercoagulability
- ☐ Documented history of DVT or PE **(3 points)**
- ☐ Estrogenic hormone use (estrogen, tamoxifen, etc.)
- ☐ Family history of DVT or PE
- ☐ Hypercoagulable states (lupus anticoagulant, etc.) **(3 points)**
- ☐ Indwelling central venous catheter
- ☐ Inflammatory bowel disease or systemic vasculitis
- ☐ Myeloproliferative disorder (non-hemorrhagic)
- ☐ Nephrotic syndrome
- ☐ Pregnant, or postpartum less than 1 month
- ☐ Severe systemic infection or sepsis
- ☐ Visceral malignancy

Risk Categories and Suggested DVT Prophylaxis

Early ambulation recommended for <u>all</u> patients, if possible.

Low Risk 1 point or less	Moderate Risk 2 points	High Risk 3 points	Very High Risk 4 points or greater
Early ambulation	Heparin <u>or</u> Sequential compression device	Heparin <u>or</u> Enoxaparin [LOVENOX]	Heparin <u>or</u> Enoxaparin [LOVENOX] <u>and</u> Sequential compression device

Anti-coagulation Medication Dosing

Medication	Usual Dose	Comments
Heparin	5,000 units subcutaneous Q8 hrs	No adjustment needed in renal insufficiency Consider lower dose for small/frail/elderly patient
Enoxaparin [LOVENOX]	40 mg subcutaneous Q24 hrs	For CrCl less than 30 mL per min: 30 mg subcutaneous Q24 hrs

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Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Day 1 of 5

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue				
	Instructions/Indications			

Comfort Medications - Do not exceed 4 grams acetaminophen per 24 hrs

- ☐ Docusate [COLACE] 100 mg PO BID (hold for diarrhea)
- ☐ Milk of magnesia 30 mL PO BID PRN constipation
- ☐ Aluminum hydroxide/magnesium hydroxide/simethicone [MYLANTA] 30 mL PO Q4 hrs PRN dyspepsia
- ☐ Bisacodyl [DULCOLAX] 10 mg 1 suppository PR Daily PRN constipation
- ☐ Acetaminophen [TYLENOL] 650 mg PO Q4 hrs PRN. Specify PRN indication(s) below.
  Mild pain   Temp. greater than 38.5° C (101.3° F)
- ☐ Other:

DVT Prophylaxis: (Calculate DVT risk from DVT Risk Assessment Tool. Head scan must be negative for hemorrhage before ordering heparin or enoxaparin).

- ☐ Risk assessment completed: pharmacologic prophylaxis risk outweighs benefit
- ☐ Heparin 5,000 units subcutaneous Q8 hrs (moderate, high or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 40 mg subcutaneous Q24 hrs (high or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 30 mg subcutaneous Q24 hrs (high or very high DVT risk, and CrCl less than 30 mL per min)
- ☐ Sequential compression device to lower extremities
- ☐ Other:

Antiplatelet - Use aspirin or Aggrenox unless contraindicated (allergy, intolerance, ulcers/GI bleeding requiring hospitalization). Use Plavix or Aggrenox for aspirin failure. Use Plavix plus low dose aspirin for patients with a history of acute coronary syndrome (ACS) within the past 6 months.

☐ Aspirin (with food)	☐ 81 mg PO Daily	☐ 325 mg PO Daily
☐ Dipyridamole 200 mg and aspirin 25 mg [AGGRENOX]	☐ 1 capsule PO BID	
☐ Clopidogrel [PLAVIX]	☐ 75 mg PO Daily	

M.D. Signature: ____________ ID#: ____________

Date: ____________ Time: ____________

R.N. Signature: ____________ Init: ____________

Date: ____________ Time: ____________

Clerk Signature: ____________ Init: ____________

Date: ____________ Time: ____________

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Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Day 1 of 5

Insulin: **Fingerstick glucose level:** ☐ Before each mealtime and at bedtime ☐ Other:_________________________

Maintenance insulin:

Give subcutaneous NPH/Regular insulin **30 minutes before meals.**
Give subcutaneous rapid acting (Lispro) insulin **with meals.**
If patient NPO: ☐ Hold Regular/rapid acting insulin. Give ½ maintenance NPH insulin dose
☐ Other:

	Breakfast	Lunch	Dinner	Bedtime
NPH	_____units		_____units	_____units
Regular	_____units	_____units	_____units	
Other:				
Other:				

Supplemental: *(Correction dose)* (1) **With each fingerstick glucose level before meals**, give additional subcutaneous Regular insulin per glucose level below, unless patient is NPO. (2) **At bedtime**, if glucose is 250 or less, give NO supplemental insulin. If glucose 251 or greater at bedtime, give ½ the supplemental dose selected. (3) If more than 8 units of supplemental insulin required in 24 hrs, call provider to re-assess and adjust maintenance insulin dose.

Less than 70 mg per dL: Hold maintenance Regular or rapid acting insulin for this one dose; continue other insulin. If alert and able to tolerate PO fluids, give 120 mL juice PO now; otherwise give 25 mL D50 slow IVP now. Repeat fingerstick glucose level in 20 min. Call provider to re-assess and adjust insulin dose.

71-150 mg per dL: No supplemental dose required.

☐ **Lower dose:**	☐ **Higher dose:**	☐ **Other:**
151-200: 2 units (None if at bedtime)	151-200: 4 units (None if at bedtime)	151-200: ___ units (None if at bedtime)
201-250: 4 units (None if at bedtime)	201-250: 6 units (None if at bedtime)	201-250: ___ units (None if at bedtime)
251-300: 6 units (3 units if at bedtime)	251-300: 8 units (4 units if at bedtime)	251-300: ___ units (___units if at bedtime)
301-350: 8 units (4 units if at bedtime)	301-350: 10 units (5 units if at bedtime)	301-350: ___ units (___units if at bedtime)
Greater than 350: 10 units, call MD	Greater than 350: 12 units, call MD	Greater than 350: ___ units, call MD

Labs/Tests: **All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.**

- ☐ CBC with differential
- ☐ Na, K, Cl, C02, BUN, Cr, Glu
- ☐ Magnesium
- ☐ Calcium
- ☐ AST, ALT, alk phos, bili-T, bili-D
- ☐ Fasting lipid panel: chol, HDL, LDL, TG
- ☐ Fingerstick glucose level Daily
- ☐ Hemoglobin A1C
- ☐ Fasting homocysteine
- ☐ High sensitivity C-reactive protein
- ☐ INR
- ☐ ANA
- ☐ Westergren sedimentation rate (ESR)
- ☐ VDRL/RPR
- ☐ Urinalysis
- ☐ HCG (all women less than 50 years of age)
- ☐ Urine toxicology screen
- ☐ Stool hemoccult X 3

- ☐ Chest x-ray PA/LAT:_________________________
- ☐ Portable chest x-ray:_________________________
- ☐ 24 hr Holter monitor: ischemic stroke
- ☐ Head CT without contrast: ischemic stroke
- ☐ MRI/MRA of head: ischemic stroke
- ☐ MRI head without gadolinium: ischemic stroke
- ☐ Carotid artery duplex study: ischemic stroke
- ☐ Transcranial Doppler ultrasound: ischemic stroke
- ☐ Transthoracic echocardiogram (TTE) with bubble study: ischemic stroke
- ☐ Transthoracic echocardiogram (TTE): ischemic stroke
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

M.D. Signature: ______________________ ID#: ______________
Date: ______________________ Time: ______________
R.N. Signature: ______________________ Init: ______________
Date: ______________________ Time: ______________
Clerk Signature: ______________________ Init: ______________
Date: ______________________ Time: ______________

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Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Physician's Orders - Day 1 of 5

Other:

M.D. Signature: ____________________ ID#: __________

Date: __________ Time: __________

R.N. Signature: ____________________ Init: __________

Date: __________ Time: __________

Clerk Signature: ____________________ Init: __________

Date: __________ Time: __________

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T-HS1037

Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Physicians Orders - Day 2 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

- ☐ If O2 saturation is greater than 94% after 1/2 hr on room air, discontinue pulse oximetry and O2 therapy

Activity:

- ☐ Ad lib (with assistance as needed)
- ☐ Ambulate in hallway at least TID (with assistance as needed)
- ☐ Soft restraints for agitation - see separate restraint order sheet

Diet:

☐ 2 gm sodium	☐ 3 gm sodium	☐ 4 gm sodium
☐ Consistent Carbohydrate (ADA)	☐ Heart Healthy (low fat, low cholesterol)	☐ Other:

Treatment:

- ☐ Convert IV to saline lock; flush per Unit protocol
- ☐ Discontinue Foley

Consults:

- ☐ Social services for:

Antilipidemic

☐ Simvastatin [ZOCOR]	☐ 20 mg PO Nightly	☐ 40 mg PO Nightly
☐ Ezetimibe/simvastatin [VYTORIN]	☐ 10 mg/20 mg PO Nightly	☐ 10 mg/40 mg PO Nightly
☐ Pravastatin [PRAVACHOL] (Restricted)	☐ 40 mg PO Nightly	

Other:

Provider Last Name (Print):		
Provider Signature:	ID#:	
Date: / /	Time: :	AM / PM
RN Last Name (Print):		
RN Signature:	Initials:	
Date: / /	Time: :	AM / PM
Clerk/LVN Signature:	Initials:	
Date: / /	Time: :	AM / PM

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Day 2

FORM NO. HS1037 (01/02/2008)

Acute Ischemic Stroke (Ward/Stepdown)

Physicians Orders - Day 3 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Activity:

☐ Ambulate in hallway at least TID (with assistance as needed)

Treatment:

☐ Convert IV to saline lock; flush per Unit protocol ☐ Discontinue sequential compression device

Neuroprotection - Do not lower BP for the first 48 hrs after ischemic stroke unless systemic pressure exceeds the upper limits of autoregulation (typically when SBP exceeds 220 or DBP exceeds 120), or unless other co-morbidities decrease the safe upper limits of blood pressure. Some evidence shows that low dose ACE inhibitors plus thiazide diuretic or ARBs may have a neuroprotective effect independent of BP control. Use these agents with caution; don't lower BP aggressively, even after 48 hrs. Stop antihypertensive meds if there is neurological deterioration.

☐ Benazepril [LOTENSIN]	☐ 10 mg PO Daily	
☐ Hydrochlorothiazide	☐ 12.5 mg PO Daily	☐ 25 mg PO Daily
☐ Losartan [COZAAR]	☐ 25 mg PO Daily	
☐ Other:		

Discharge Plan:

☐ Anticipate discharge within the next 24 hrs

GOALS:

- ► Write discharge order by 9:00 a.m. and discharge patient by 12:00 noon
- ► Send discharge medication prescription(s) to pharmacy today
- ► Arrange for home durable medical equipment/supplies as needed

Schedule follow-up outpatient clinic appointment in __________days__________week(s)

Specify clinic/location/MD:____

☐ Discharge unlikely within the next 24 hrs

Other:

Provider Last Name (Print):				
Provider Signature:		ID#:		
Date: / /		Time:	:	AM / PM
RN Last Name (Print):				
RN Signature:			Initials:	
Date: / /		Time:	:	AM / PM
Clerk/LVN Signature:			Initials:	
Date: / /		Time:	:	AM / PM

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Day 3

FORM NO. HS1037 (01/02/2008)

Acute Ischemic Stroke (Ward/Stepdown)

Physicians Orders - Day 4 of 5

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INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Activity:

☐ Ad lib

Treatment:

☐ Discontinue sequential compression device

Discharge Plan:

☐ Anticipate discharge within the next 24 hrs

GOALS:

- ► Write discharge order by 9:00 a.m. and discharge patient by 12:00 noon
- ► Send discharge medication prescription(s) to pharmacy today
- ► Arrange for home durable medical equipment/supplies as needed

Schedule follow-up outpatient clinic appointment in __________days__________week(s)

Specify clinic/location/MD:____

☐ Discharge unlikely within the next 24 hrs

Other:

Provider Last Name (Print):			
Provider Signature:		ID#:	
Date: / /		Time:	: AM / PM
RN Last Name (Print):			
RN Signature:		Initials:	
Date: / /		Time:	: AM / PM
Clerk/LVN Signature:		Initials:	
Date: / /		Time:	: AM / PM

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Acute Ischemic Stroke (Ward/Stepdown)

Physicians Orders - Day 5 OR Discharge Day

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Treatment:

- ☐ Discontinue saline lock

Discharge Plan:

- ☐ Discharge patient today (Goal: discharge by 12:00 noon)
  - ☐ Discharge discussed with attending and attending concurs
  - ☐ Influenza vaccine and Pneumovax considered prior to discharge
  - ☐ Anticoagulant therapy considered for atrial fibrillation prior to discharge
  - ☐ Antithrombic medication considered and prescribed as appropriate prior to discharge
- ☐ Do not discharge today due to: (Note: pathway orders will continue)
  - ☐ Change in neurological status
  - ☐ Other:

Other:

Provider Last Name (Print):		
Provider Signature:	ID#:	
Date: / /	Time: :	AM / PM
RN Last Name (Print):		
RN Signature:		Initials:
Date: / /	Time: :	AM / PM
Clerk/LVN Signature:		Initials:
Date: / /	Time: :	AM / PM

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T-HS1037

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Admission Date: ___/___/____ **Time:**____________	**On Pathway Date:** ___/___/____ **Time:**____________

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment													
1. O2 saturation 94% or greater		☐	☐		☐	☐		☐	☐		☐	☐	
2. Skin assessment within normal limits		☐	☐		☐	☐		☐	☐		☐	☐	
3. Old chart available within 12 hrs of MD order	☐				☐	☐							
2. Physician Notification													
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐		☐	☐	

- Systolic BP per physician's orders
- Diastolic BP per physician's orders
- Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F)
- Pulse less than 55 or greater than 100 BPM
- Resp. rate less than 12 or greater than 30
- O2 saturation less than 94% with or without O2 administered
- Blood glucose greater than 175 mg per dL
- Change in neurological status
- Increased agitation
- Urinary output: less than 240 mL within 8 hrs

Care Elements: Care Events/Outcomes	Not Ordered	(N) Y	(N) N	(N) Init.	(D) Y	(D) N	(D) Init.	(E) Y	(E) N	(E) Init.	(N) Y	(N) N	(N) Init.
3. Consults													
1. All consults obtained as ordered	☐				☐	☐							
4. Diet													
1. *Consumed and tolerated ordered diet*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
5. Activity													
1. *Ordered activity tolerated*		☐	☐		☐	☐		☐	☐		☐	☐	
6. Teaching Plan													
1. Patient verbalizes understanding of pain scale and pain intervention options					☐	☐							
2. CRM inpatient teaching guide given to patient/family/significant other					☐	☐							
7. Medication													
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
8. Treatment													
1. All treatments completed as ordered	☐				☐	☐							
9. Labs/Tests													
1. All diagnostic tests performed as ordered	☐				☐	☐							

Signature/Title:______________________ Init.:________ Date:________

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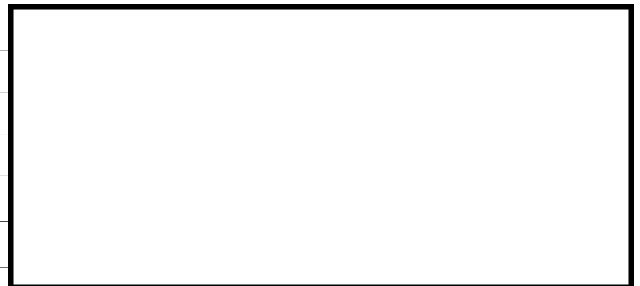

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Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan													
1. Discharge plan initiated					☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:________ Init.:________ Date:________

Signature/Title:________ Init.:________ Date:________

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T-HS1037

Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title:______________ Init.:______ Date:______

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Day 1

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 2 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. O2 saturation 94% or greater	☐	☐	☐		☐	☐		☐	☐	
2. Skin assessment within normal limits		☐	☐		☐	☐		☐	☐	
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	

- Systolic BP per physician's orders
- Diastolic BP per physician's orders
- Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F)
- Pulse less than 55 or greater than 100 BPM
- Resp. rate less than 12 or greater than 30
- O2 saturation less than 94% with or without O2 administered
- Blood glucose greater than 175 mg per dL
- Change in neurological status
- Increased agitation
- Urinary output: less than 240 mL within 8 hrs

Care Elements: Care Events/Outcomes	Not Ordered	(D) Y	(D) N	(D) Init.	(E) Y	(E) N	(E) Init.	(N) Y	(N) N	(N) Init.
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet	☐	☐	☐		☐	☐		☐	☐	
2. **Bedside or formal swallow study completed**	☐	☐	☐							
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. *Patient/family/significant other verbalizes understanding of CRM inpatient teaching guide*		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. *All treatments completed as ordered*	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. *All diagnostic tests performed as ordered*	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

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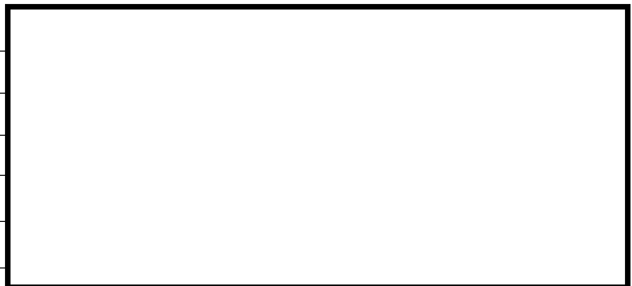
Signature/Title:______________________ Init.:________ Date:________



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Day 2

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 2 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title:	Init.:	Date:
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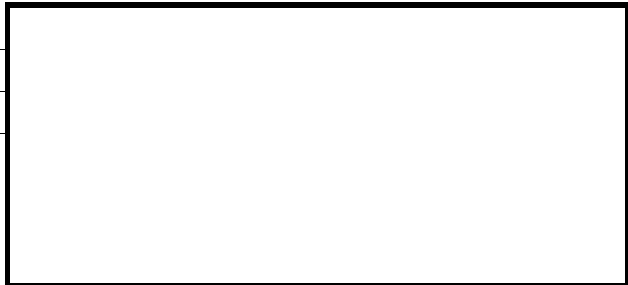

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T-HS1037

Day 2

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 3 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. Skin assessment within normal limits		☐	☐		☐	☐		☐	☐	
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP per physician's orders • Diastolic BP per physician's orders • Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F) • Pulse less than 55 or greater than 100 BPM • Resp. rate less than 12 or greater than 30 • O2 saturation less than 94% with or without O2 administered • Blood glucose greater than 175 mg per dL • Change in neurological status • Increased agitation • Urinary output: less than 240 mL within 8 hrs										
3. Consults										
1. Nutrition consult completed	☐	☐	☐							
2. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
2. **Patient tolerates being out of bed**	☐	☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. *All treatments completed as ordered*	☐	☐	☐							
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

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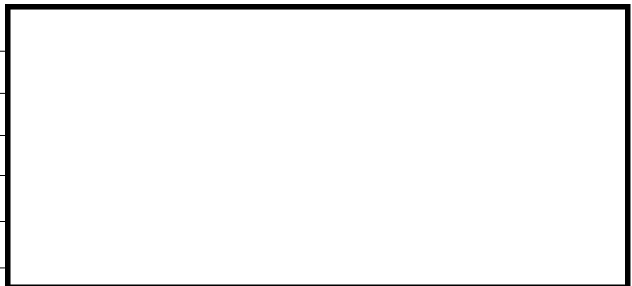

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Day 3

FORM NO. HS1037 (01/02/2008)

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 3 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

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Day 3

Acute Ischemic Stroke (Ward/Stepdown)
Daily Care Documentation - Day 4 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. O2 saturation 94% or greater on room air	☐	☐	☐		☐	☐		☐	☐	
2. Skin assessment within normal limits		☐	☐		☐	☐		☐	☐	
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP per physician's orders • Diastolic BP per physician's orders • Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F) • Pulse less than 55 or greater than 100 BPM • Resp. rate less than 12 or greater than 30 • O2 saturation less than 94% with or without O2 administered • Blood glucose greater than 175 mg per dL • Change in neurological status • Increased agitation • Urinary output: less than 240 mL within 8 hrs										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
2. **Patient ambulates without assistance**	☐	☐	☐							
6. Teaching Plan										
1. *Patient/family/significant other received CRM post-discharge teaching guide and verbalizes understanding of diet, activity and exercise, medications, smoking cessation and counseling including secondhand smoke, follow-up appointment, what to do if symptoms worsen and when to seek medical care*		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. *All treatments completed as ordered*	☐	☐	☐							
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Signature/Title:________________ Init.:______ Date:______

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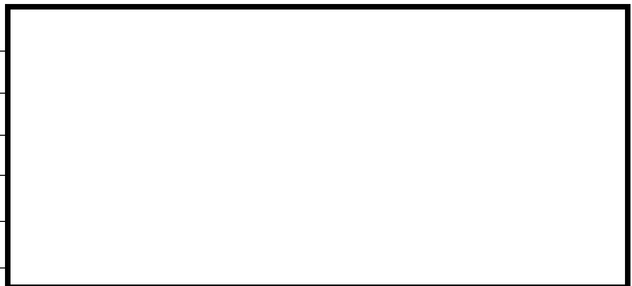

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Acute Ischemic Stroke (Ward/Stepdown)
Daily Care Documentation - Day 4 of 5

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan										
1. *Discharge transportation arranged/confirmed*		☐	☐							
2. Outpatient rehabilitation follow-up has been scheduled	☐	☐	☐							
3. Home durable medical equipment successfully arranged today	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:________________ Init.:________ Date:________

Signature/Title:________________ Init.:________ Date:________

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Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 4 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

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Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 5 OR Discharge Day

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. O2 saturation 94% or greater on room air	☐	☐	☐		☐	☐		☐	☐	
2. Skin assessment within normal limits	☐	☐	☐		☐	☐		☐	☐	
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP per physician's orders • Diastolic BP per physician's orders • Temp. less than 36.1° C (97.0° F) or greater than 38.5° C (101.3° F) • Pulse less than 55 or greater than 100 BPM • Resp. rate less than 12 or greater than 30 • O2 saturation less than 94% with or without O2 administered • Blood glucose greater than 175 mg per dL • Change in neurological status • Increased agitation • Urinary output: less than 240 mL within 8 hrs										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. *Patient/family/significant other received CRM post-discharge teaching guide and verbalizes understanding of diet, activity and exercise, medications, smoking cessation and counseling including secondhand smoke, follow-up appointment, what to do if symptoms worsen and when to seek medical care*		☐	☐							
7. Medication										
1. *Influenza vaccine given*	☐	☐	☐							
2. *Pneumovax vaccine given*	☐	☐	☐							
3. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
4. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. Saline lock removed	☐	☐	☐							
2. All treatments completed as ordered	☐	☐	☐							
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Signature/Title:______________________ Init.:________ Date:__________

Signature/Title:______________________ Init.:________ Date:__________

Signature/Title:______________________ Init.:________ Date:__________

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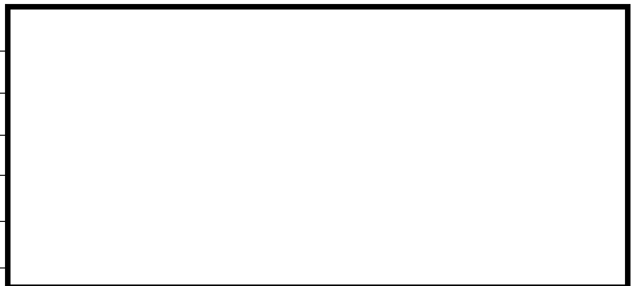

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Acute Ischemic Stroke (Ward/Stepdown)
Daily Care Documentation - Day 5 OR Discharge Day

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan										
1. *A clinic follow-up appointment is scheduled within the next 30 days*	☐	☐	☐							
2. *Patient has sufficient medication to last until first clinic appointment*	☐	☐	☐							
3. **Patient to be discharged today**		☐	☐							
4. **Discharge orders written by 9:00 a.m.**		☐	☐							
5. **Patient discharged by 12:00 Noon**		☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

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County of Los Angeles Department of Health Services

Acute Ischemic Stroke (Ward/Stepdown)

Daily Care Documentation - Day 5 OR Discharge Day

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

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Signature/Title: ____ Init.: ____ Date: ____

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You are recovering from stroke…what's next?

You are recovering from a stroke. We want you to be as comfortable as possible while you recover. **Here's what will happen in the next few days:**

What will I be able to eat?

- People with stroke often have trouble swallowing.
  Someone will check to make sure you can swallow.
- Once your doctor says it is safe for you to start eating, you will be given food.

When will I be able to get out of bed?

- You will need to stay in bed the first day.
- Some people with stroke have trouble walking.
- Your doctor or nurse will let you know when you can get out of bed.
- Walk as much as your doctor tells you.

What if I have pain?

- If you have pain, tell your nurse. You will be asked to rate your pain on a scale of 0 to 10 (0 = no pain and 10 = worst pain).
- You may be given pills to control your pain.

How do I know if I'm getting better?

- Your blood pressure, pulse, temperature and breathing will be checked during the day and night. If there are any changes, the doctor will be called.
- The nurse will measure your intake (everything you eat and drink) and output (urine and stool) to make sure your body has returned to its normal function.
- If you have chest pain or trouble breathing, call your nurse immediately.

What else will happen while I'm here?

- Your nurse may assist you in turning from side to side every few hours.
- You may be asked to do breathing exercises, such as coughing and breathing deeply.
- You may have blood drawn for lab tests.
- You may be seen by a speech therapist and physical therapist.

When can I go home?

- Your doctor or nurse will tell you when you will be ready to go home.
- The nurse will go over ALL discharge instructions with you.
- Please plan to have someone pick you up by 12 noon.
- You may get prescriptions/medication(s) before going home and a clinic appointment will be scheduled.
- Your doctor will talk to you about limits on your activity, and when you can return to work.

What else do I need to know?

- If you smoke, STOP! Smoking increases your risk of having another stroke or a heart attack.
- Talk to your doctor or nurse if you need help quitting.
  You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.
- If you have any questions or are unsure about something, ask your nurse.

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Usted esta recuperándose de una embolia…que sigue?

Usted esta recuperándose de una embolia. Queremos que se sienta los mas cómodo posible mientras se recupera.

Aquí es lo que va a pasar durante los siguientes días:

Que es lo que puedo comer?

- Personas que padecen de un embolio, frecuentemente tienen molestias al tragar. Alguien revisara para asegurar que puede tragar.
- Cuando su doctor le avise que no hay peligro de que pueda empezar a comer, se le dará comida.

Cuando podré levantarme de la cama?

- Usted necesitara quedarse en cama el primer día.
- Algunas personas que padecen de una embolia tienen molestias al caminar.
- Su doctor o enfermera le hará saber cuando puede levantarse de la cama.
- Camine tal como se lo indique su doctor.

Y si tengo dolor?

- Si usted tiene dolor, dígale a su enfermera. Se le pedirá que describa su dolor en una escala del 0 al 10 (0 = ningún dolor y 10 = el peor dolor).
- Puede ser que le den pastillas para controlar su dolor.

Como reconozco si estoy mejorando?

- Su presión de sangre, pulso, temperatura y respiración se le revisara durante el día y la noche. Si hay algún cambio, se le llamara al doctor.
- La enfermera le medirá lo que consuma (todo lo que come y bebe) y lo que desecha (orina y excremento) para asegurar que su organismo ha regresado a sus funciones normales.
- Si usted tiene dolor en el pecho o dificultades respirando, llame a su enfermera inmediatamente.

Que mas pasara mientras estoy aquí?

- Su enfermera puede ayudarle a voltear de lado a lado cada pocas horas.
- Puede ser que le pidan que haga ejercicios de respiración, como toser y respirar profundamente.
- Puede ser que le saquen sangre para exámenes de laboratorio.
- Puede ser que sea visto(a) por un terapista de lenguaje y terapista físico.

Cuando puedo irme a mi casa?

- Su doctor o enfermera le dirá cuando usted esta listo(a) para irse a casa.
- La enfermera revisara TODAS las instrucciones de alta con usted.
- Por favor proponga que alguien venga por usted para las 12 del medio día.
- Puede ser que usted reciba receta/medicamento(s) antes de irse a casa y una cita de clínica será establecida.
- Su doctor le hablara de los limites de su actividad y cuando puede regresar a trabajar.

Que mas debo saber?

- Si fuma, PARE! Fumar le aumentara el riesgo de tener otra embolia o ataque al corazón.
- Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). No esta solo(a), podemos ayudar.
- Si tiene alguna pregunta o no esta seguro(a) de algo, pregúntele a su enfermera.

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Thank you for choosing the County of Los Angeles Department of Health Services as your Health Care Provider

Clinical
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Questions/Notes

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Your Follow-up Appointment(s)

Date________________Time_____________

Location______________________________

Phone Number_________________________

Date________________Time_____________

Location______________________________

Phone Number_________________________

It is very important to keep all appointments for follow-up care. If you are unable to keep your clinic appointment(s), please call and let us know.

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Comments regarding this form? Call (818) 364-3566

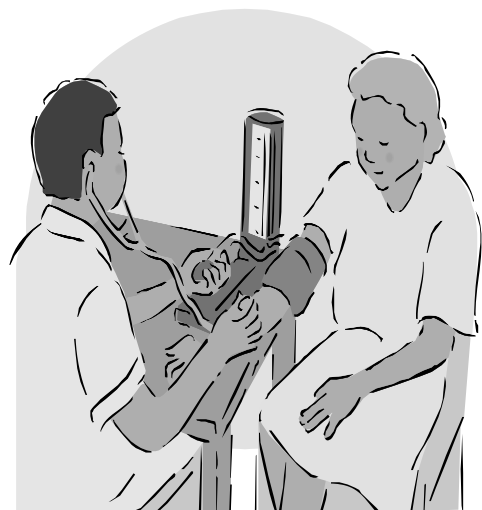
County of Los Angeles Department of Health Services

Recovering from stroke:

Now that you are home from the hospital, it is important that you rest and take care of yourself.

This guide will help you to get healthy again. It will tell you about caring for yourself.

We hope you feel better very soon!



Stroke

What is a stroke?

A stroke is a sudden loss of brain function. This is due to a change in the blood flow to the brain.

How active should I be?

- During your first weeks at home, let comfort be your guide. Rest as much as you need to. Start normal activities as soon as possible.
- Walk as much as is comfortable. Rest when you feel tired.
- Your nurse will tell you if there is anything you should not do.

What activities should I avoid?

- Do not drive or operate machinery while taking pain medication(s) because it may cause drowsiness.
- If you choose to drink alcohol, do so in moderation (not more than two drinks a day).
- Avoid any type of recreational drugs.

What should I do at home?

- Sleep at least eight hours each night.
- Lower your stress level by doing relaxation exercises and enjoying recreation activities.
- Exercise regularly at least 3 times per week, for 30 continuous minutes.
- Maintain proper weight. Obesity is a risk factor for another stroke.

How do I avoid getting an infection?

- Maintain proper hygiene by washing your hands.

What should I eat?

Eat a low fat, low cholesterol diet.

You may become constipated from taking your medication. To avoid this, eat plenty of fruits and vegetables each day. Drink lots of water too!

Will I have to take medication?

To help with your recovery, it is very important to take all medication(s). Follow all directions given to you by the doctor or nurse.

Is it okay if I smoke?

If you smoke, STOP. Smoking slows healing so it takes longer to get better. Smoking can lead to another stroke. Talk to your doctor or nurse if you need help quitting. You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.

When should I call my doctor/clinic?

- If you have symptoms that feel like a stroke.
- If you have sudden weakness of your arm or leg.
- If you have trouble seeing in one or both eyes, such as dimness, blurring or double vision.
- If you are confused or have trouble speaking.
- If you have a severe headache with no known cause.
- Visit your doctor regularly to check your blood pressure, blood sugar and cholesterol.

Gracias por elegir El Departamento de Salud del Condado de Los Ángeles como el Proveedor de Cuidado de su Salud

Clinical Resource Management

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Preguntas/Notas

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Su proxima cita(s)

Fecha______________Hora___________

Lugar____________________________

Numero de teléfono___________________

Fecha______________Hora___________

Lugar____________________________

Numero de teléfono___________________

Es muy importante que mantenga todas sus citas. Si usted no puede presentarse a su cita(s) de clínica, haga el favor de llamarnos con tiempo.

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Comments regarding this form? Call (818) 364-3566

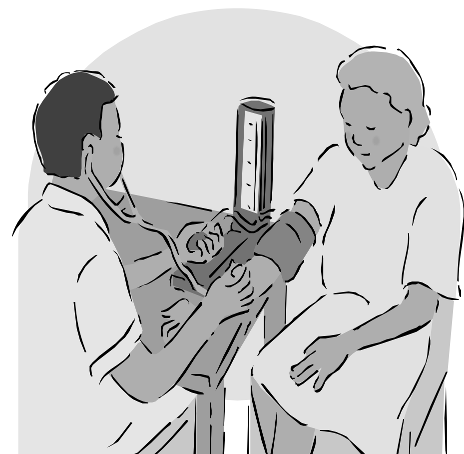
El Departamento de Servicios de Salud del Condado de Los Ángeles

Recuperando de una embolia**:**

Ahora que esta de regreso del hospital y en casa, es importante que usted descanse y se cuide.

Este guía le ayudara a usted obtener su salud nuevamente. Le dirá como cuidarse.

Esperamos que se sienta mejor muy pronto!



Embolia

Que es una embolia?

Una embolia es un daño inesperado de la función del cerebro. Esto es debido al cambio de la corriente de sangre en el cerebro.

Que activo(a) debo de ser?

- Durante sus primeras semanas en casa, deje que su comodidad sea su guía. Descanse tal como usted lo sienta necesario. Regrese a sus actividades normales los mas pronto posible.
- Camine los mas que pueda a su comodidad. Descanse cuando se sienta cansado(a).
- Su enfermera le dirá si hay algo que no debe de hacer.

Que actividades debo de evitar?

- No maneje ni opere maquinaria mientras este tomando medicamento(s) para el dolor porque puede causarle somnolencia.
- Si usted elije tomar bebidas de alcohol, hágalo con moderación (no mas de dos bebidas por día).
- Evite cualquier droga recreativa.

Que debo de ser en casa?

- Duerma por lo menos ocho horas cada noche.
- Baje su nivel de tensión haciendo ejercicios de relajación y disfrutando de actividades recreativos.
- Haga ejercicio regularmente por los menos de 3 veces por semana, por 30 minutos continuos.
- Mantenga su peso apropiado. La obesidad es un elemento de riesgo para otra embolia.

Como evito de conseguir una infección?

- Mantenga higiene apropiado lavándose las manos.

Que debo comer?

Coma una dieta bajo en grasa y bajo en colesterol.

Puede estreñirse por causa de los medicamentos. Para evitar estreñimiento, coma bastante frutas y vegetales cada día. Tome mucha agua también!

Es necesario que tome medicamento?

Para ayudar con su recuperación, es muy importante que tome todo su(s) medicamento(s). Siga todas las ordenes que le de su doctor o enfermera.

Esta bien que fume?

Si fuma, PARE. Fumando lo(a) hará sanar lentamente y tardara mas para que mejore. Fumando puede causarle otra embolia. Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). No esta solo(a), podemos ayudar.

Cuando debo de llamar a mi doctor/clinica?

- Si tiene síntomas que se siente como una embolia.
- Si tiene debilidad inesperada de su brazo o pierna.
- Si tiene molestias con la vista en un ojo o los dos ojos, tal como oscuridad, borroso o doble visión.
- Si tiene confusión o problemas al hablar.
- Si tiene un fuerte dolor de cabeza sin causa ninguna.
- Visite su doctor regularmente para revisar su presión de la sangre, azúcar en la sangre y colesterol.