

STROKE MANAGEMENT PLAN

FACILITY: _____

THS – North

PT ID							
SURNAME	D.O.B.						
OTHER NAMES							
ADDRESS							

Attach Patient Sticker Label

Stroke Management Plan including Thrombolysis Protocol

Guideline / Protocol Reference:

- Stroke Unit Admission Guidelines April 2015.
- Dysphagia Management Policy No. 04/13
- Interim After-hours Dysphagia Screening Policy no 43/10
- Automatic Allied Health referral for Stroke “CVA” and Transient Ischemic Attack “TIA” patients 71/13
- Guidelines for antiplatelet / anticoagulation after an acute stroke October 2004.
- National Acute Stroke Guidelines 2010.

Symptom Management

- Medical review of BP outside 200 / 110 guideline
- Assess and document localisation of pain
- Glasgow Coma Scale Score less than 8 notify R.M.O.
- If patient is coughing post consumption of fluids or diet notify speech pathologist for review

Date of Admission	Expected Length of Stay		Date of Discharge / Transfer	Discharge / Transfer Destination	
Unit / Ward	Patient Status	Neurological Incident			Hemisphere
Stroke Unit <input type="checkbox"/>	Public <input type="checkbox"/> Private <input type="checkbox"/>	Infarct <input type="checkbox"/> T.I.A. <input type="checkbox"/>	Haemorrhage <input type="checkbox"/> Undefined <input type="checkbox"/>	SAH <input type="checkbox"/> <input type="checkbox"/>	Left <input type="checkbox"/> Right <input type="checkbox"/> Brainstem <input type="checkbox"/>

Consultant:**Medical Officer:**
ACHS CLINICAL INDICATOR NEUROLOGY CI No. 6.1 (This indicator relates to new strokes only).

For the purpose of this indicator only patients separated from hospital with a discharge diagnosis of stroke that had a documented CT scan. Did the patient have a CT scan during this admission? Yes No

R.M.O. Name and initial:

This section is to be completed by Medical Registrar prior to the patient's discharge from hospital.

	NAME	DATE & TIME
DOCTOR		
CNC		
PHYSIOTHERAPIST		
SPEECH PATHOLOGIST		
OCCUPATIONAL THERAPIST		
SOCIAL WORKER		
DIETITIAN		



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VARIANCES CODES

A. PATIENT	B. CLINICAL
1. BP outside 200 / 110 guideline	1. Delay in medical consultation
2. Pain	2. Nursing assessment not completed within 24 hours
3. Fall	3. Delay in Allied Health consultation (specify)
4. Telemetry	4. Incomplete discharge assessment / planning
5. IV fluids	5. Other (specify) _____
6. Blood Glucose Levels	
7. Temperature > 38.0C	
8. Other (specify)	
C. SYSTEM	D. COMMUNITY
1. Delay in CT Scan > 12 hours	1. Delay in transport
2. Delay in antiplatelet therapy > 48 hours	2. Delay in placement /Residential Care Facility bed
3. Delay in test result	3. Delay in availability of private hospital bed
4. Delay in X-ray	4. Early availability of discharge option
5. Delay in transfer to Rehabilitation Ward	5. Other (specify) _____
6. Other (specify)	

	ADVERSE EVENTS INDICATORS	Initial	Date
Medical	Aspiration pneumonia..... UTI AMI Pulmonary Embolism DVT Gastrointestinal Bleed..... Haemorrhagic transformation of ischaemic management Post stroke depression requiring medical management..... Subluxation of Shoulder..... Pressure sore..... Fall Other sepsis (please specify)
PRINT NAME AND TITLE	INITIAL	PRINT NAME AND TITLE	INITIAL

**STROKE MANAGEMENT
PROFILE - EMERGENCY DEPT.**

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STROKE MANAGEMENT PROFILE / EMERGENCY DEPARTMENT DATE / /

	Investigation / Intervention	V	Initial	Date
Presentation	Onset of symptoms. Presentation to DEM Candidate for thrombolysis Yes / No If Yes refer to thrombolysis protocol If No please state why.....			
Assessment	Medical: Assessment and Documentation completed..... Stroke Consultant notified of patient admission..... ('v' if No) Nursing: Assessment and Documentation completed.....			
Monitoring	Neuro observations as indicated by clinical condition..... Blood glucose level.....			
Investigation	CT Brain <input type="checkbox"/> CXR <input type="checkbox"/> ECG <input type="checkbox"/> FBC <input type="checkbox"/> Coag Profile <input type="checkbox"/> UCE <input type="checkbox"/> LFT <input type="checkbox"/> ESR <input type="checkbox"/>			
Treatment	Oxygen therapy if indicated:..... PIVC Yes <input type="checkbox"/> Nil by mouth until speech pathology review..... IV therapy if indicated.....(V if Glucose solution administered) Stat Aspirin ordered and administered for ischemic events not receiving thrombolysis post dysphagia screening.....			
PRINT NAME AND TITLE	INITIAL	PRINT NAME AND TITLE		INITIAL

TIA Risk Assessment Score

- Age greater than 60 years (1)
- Blood pressure greater than 140/90 (1)
- Clinical Features: unilateral weakness (2), speech impairment without weakness (1)
- Duration >60 mins (2), 10-59 mins (1)
- Diabetes (1)

Risk assessment score > or = to 4: Assess and consider for admission to the Stroke Unit.

Risk assessment score < 4: Discharge with Secondary Prevention Follow-up with either GP or Stroke Clinic.

oICH Score	IVH	No (0)
GCS Score		Yes (1)
13-15 (0)		Infratentorial Region
5-12 (1)	No (0)	
3-4 (2)	Yes (1)	
ICH Volume	Age	
> 30 (0)	< 80 (0)	
< 30 (1)	> 80 (1)	
If patient scores 0 to 3 refer to neurosurgery RHH.		
If patients score 4 to 6 refer to Med Reg for admission to Stroke Unit.		

THROMBOLYSIS PROTOCOL

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THROMBOLYSIS OF ACUTE ISCHAEMIC STROKE PATIENTS

A patient over the age of 18 with the clinical diagnosis of stroke that presents to the Department of Emergency Medicine within 3 hours of onset of neurological symptoms and with a measurable neurological deficit which is expected to result in long term disability. If the exact time is not known then the onset is defined, as the last time the patient was known to be normal.

Medical Staff Requirements		Nursing Staff Requirements	
	Initial		Initial
Senior DEM Review	2 x IV access
Neuro Examination	ECG
Medical History	Urgent bloods taken
NIH Stroke Scale <input type="text"/>	15 minute neuro obs and BP monitoring
		Maintain blood pressure below 180/110
Urgent CT Head	Request family to remain
Urgent Bloods ordered	Ensure pathology is aware that the bloods need to be tested immediately.
FBC, Glucose, UE, COAGS, Blood Group and hold		
Contact Stroke Consultant		
Review urgent bloods	Weight _____
If INR \geq 1.4 do not give.		
Review CT Scan results with Radiologists	Headache present pre commencement of infusion Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Complete Exclusion Criteria		
CONSENT		
Administer Alteplase as per protocol Use STROKE DOSE of alteplase. Refer to LGH Pharmacy Administration protocol manual for further details. Administer Alteplase at a dose of 0.9mg/kg (up to a maximum of 90mg) given as a 10% intravenous bolus (maximum of 9mg) and the remainder of the dose as a 1-hour intravenous infusion	Neurological observations and blood pressure monitoring Every 15 minutes for 2 hours, then; Every 30 minutes for 6 hours, then; Hourly for 16 hours Maintain blood pressure below 180/110
Admit to either ICU or Stroke Unit only	Notify CNC Stroke Unit of thrombolysed patient
PRINT NAME AND TITLE	INITIAL	PRINT NAME AND TITLE	INITIAL

Suspect ICH if any of the following occurs during the first 24 hours. Contact Stroke Registrar or Consultant immediately if Neurological deterioration.
 New headache
 New acute hypertension
 New nausea or vomiting

If ICH is suspected
 Consider Stopping infusion if still running.
 Bloods: FBC, APTT, INR, plats, fibrinogen. Group and hold Urgent CT head without contrast.
 Surgical consultation and/or haematologist consult.

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EXCLUSION CRITERIA FOR THROMBOLYSIS

	Yes	No
Head CT SCAN		
Evidence of Haemorrhage.		
Evidence of early infarction signs such as diffuse swelling of the affected hemisphere, sulcal oedema, parenchymal Hypodensity and / or effacement of > 33% of the MCA territory.		
Likely aetiology other than acute brain ischaemia.		
History		
Clinical suspicion of uncontrolled diabetes, anticoagulation or thrombocytopenia. Appropriate investigations of these should be explored.		
Past history of Stroke, intracranial/intraspinal surgery or significant head injury within the last 3 months.		
Prior history of intracranial haemorrhage.		
Major surgery within last 3 months, minor surgery in last 10 days.		
Gastrointestinal, respiratory or genitourinary bleeding within the 3 months.		
Myocardial infarction within last 3 months.		
Received Alteplase in the last 7 days.		
Lumbar puncture and or Arterial puncture at a non-compressible site within the last week.		
Intracranial neoplasm, arteriovenous malformation, or aneurysm.		
Known bleeding diathesis either acquired or hereditary (including secondary to renal or hepatic disease).		
CLINICAL		
Rapidly improving neurological stroke symptoms.		
Minor or isolated neurological signs (NIHSS score <4)		
Seizure at onset of stroke with post-ictal residual neurological impairments.		
Symptoms suggestive of subarachnoid haemorrhage even with a normal CT scan result.		
Persistent systolic BP > 185, diastolic BP > 110mmHg, or requiring aggressive therapy to control BP.		
Pregnancy (and up to 30 days postpartum) or lactation.		
Active bleeding or acute trauma (fracture).		
Bacterial endocarditis.		
Clinical presentation suggestive of an AMI or post-AMI pericarditis.		
Severe symptoms suggesting total anterior circulation syndrome (coma or severe obtundation with fixed eye deviation and complete hemiplegia or NIHSS score >22).		
INITIAL SIGNATURE		



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MANAGEMENT OF HYPERTENSION PRE, POST AND DURING THROMBOLYSIS ONLY

The following should only be used a guide and any management of hypertension should be discussed with the Stroke Consultant. Blood pressure should be monitored 15 minute and maintained below 180 / 110 mmHg and greater than 160 / 90 mmHg. If the patient's blood pressure exceeds these parameters treat with a GTN infusion 50mg / 500mLs Dextrose 5%, start at 3ML/1hr, titrate until BP < 180 / 110 mmHg.

If BP remains high contact Stroke Consultant immediately to consider admission to ICU for treatment of hypertension with Sodium Nitroprusside.

During hypertension management therapy 15 minute blood pressure and neurological assessment continues. If intracranial haemorrhage is suspected cease IV thrombolysis and consult Stroke Consultant for further management.

BLEEDING PRECAUTIONS

- Avoid placement of central venous access or arterial puncture for the first 24 hours
- Placement of an indwelling bladder catheter should be avoided during drug infusion and for at least 30 minutes after infusion ends.
- Insertion of a naso-gastric tube should be avoided, if possible, during the first 24 hours
- Avoid use of anticoagulant, antiplatelet, or non-steroidal anti-inflammatory agents for the first 24 hours
- Before commencing antiplatelet therapy or anticoagulants, a non-contrast CT scan should be performed to rule out intracranial hemorrhage 24 hours after alteplase and commence only after exclusion of intracranial haemorrhage.

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Demographic information

Admission date: _____ Admission time: _____

Past Medical History:

Known allergies:

Diagnosis/type of stroke:

DISCHARGE PLANNING / EDUCATION
 My Stroke Journey Attended Stroke Club
SERVICES:
 Nil CHNS Home Help MOW CACP Post Acute HACC
 COS COSNESB EACH CDT(Community Dementia Team) DVA
 Disability Services Personal Alarm

Provider details:

SOCIAL / CULTURAL ENVIRONMENT
 Home Alone Home with Family Hostel Nursing Home

 Housing Services Other

 Administration Order Enduring Power of Attorney Copy provided

 Enduring Guardianship Guardianship Order Copy provided

Main Contact (Relationship): _____ Contact Ph: _____

Key Supports:

PSYCHOSOCIAL CONCERNs
 Income Source: Health Care Card MAIB DVA Centrelink payment

 Employment Superannuation Supported
Language: English; Other: Interpreter: Yes No GP: Consent to contact service providers**PHYSICAL ENVIRONMENT****Front Access****Back Access****Internal****Outdoor**

Heating:

Bathroom: Shower Recess Shower-Over-Bath Bath Level access shower**Toilet:****Bedroom****Seating:**

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Pre- morbid functional status

SELF MAINTENANCE	
Mobility and Stair climbing	
Transfers: Bed, chair, w/c	
Transfers: Toilet	
Transfers: Bath/shower	
Falls History	
Eating	
Grooming	
Bathing	
Dressing	
Toileting	
Continence	
Medication Management	
Rest/Sleep	
PRODUCTIVITY	
Shopping	
Meal Preparation	
Cleaning	
Laundry	
Garbage	
Lawns/Gardens	
Money Management	
Community Access	
Work	
Leisure	

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COMMUNICATION ASSESSMENT (LEVEL OF IMPAIRMENT)

RECEPTIVE LANGUAGE (APHASIA)

- Understands Yes / No questions Follows verbal instructions Follows conversation appropriately
 Reading comprehension intact

EXPRESSIVE LANGUAGE (APHASIA)

- Word finding difficulties Paraphasias Speaking in full sentences appropriately Written output intact

MOTOR SPEECH (DYSPRAXIA)

- Oral dyspraxia evident Automatic speech preserved Sound sequencing errors Groping of articulators

ORAL MOTOR IMPAIRMENTS (DYSARTHRIA/DYSPHAGIA)

Jaw: _____ Lips: _____ Tongue: _____ Soft Palate/Larynx: _____

MOTOR SPEECH (DYSARTHRIA)

- At Premorbid level Mildly impaired Moderately impaired Severely impaired
 Decreased breath support Impaired resonance Impaired articulatory precision Impaired speech rate

RECOMMENDED COMMUNICATION STRATEGIES:

SWALLOWING ASSESSMENT

PRE-ORAL ISSUES:

ORAL IMPAIRMENT:

PHARYNGEAL IMPAIRMENT:

TEXTURES TRIALLED:

- normal texture soft minced puree unmodified/regular fluids thickened fluids



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MEAL MANAGEMENT RECOMMENDATIONS

<input type="checkbox"/> Feed only when alert and attentive	<input type="checkbox"/> NWD
<input type="checkbox"/> Upright positioning, head in midline	<input type="checkbox"/> Soft
<input type="checkbox"/> Normal fluids	<input type="checkbox"/> 3M
<input type="checkbox"/> Full feed by nursing staff	<input type="checkbox"/> Puree
<input type="checkbox"/> Remind patient to tilt chin down during swallows	<input type="checkbox"/> NBM
<input type="checkbox"/> Regularly check mouth clearing	<input type="checkbox"/> Thick fluids
<input type="checkbox"/> Cease feeding if coughing	<input type="checkbox"/> Regular fluids
<input type="checkbox"/> Other	<input type="checkbox"/> Ice Chips only
	<input type="checkbox"/> Mouth care (swabs)

Presentation- Date:

Alert: Yes No Fatigue: Yes No Tolerance to screen - Minutes

Hearing - Date:

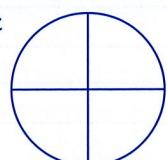
Normal Impaired Hearing aids No aids

Vision - Date:

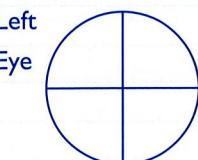
Pre-morbid status: Normal Impaired Glasses Contacts Wears aids at all times
 Reading Other **Comments:**

Ocular posture: Normal Impaired **Visual field:** (Deficits indicated by colouring in relevant fields/quadrants):

Right Eye



Left Eye

**Visual tracking:** Normal Impaired **Diplopia** **Blurred vision**



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Cognition- Date:	Assessor:	Profession:			
Orientation (tick or cross):					
Day <input type="checkbox"/>	Date <input type="checkbox"/>	Month <input type="checkbox"/>	Year <input type="checkbox"/>	Age <input type="checkbox"/>	Location <input type="checkbox"/>
Registration (for memory recall): School <input type="checkbox"/> Blue <input type="checkbox"/> Dog <input type="checkbox"/> Number of repetitions required: _____					
Recall (For memory task):					
Without prompts (tick)	Category prompts (tick)		Multiple choice (circle)		
School <input type="checkbox"/>	Building <input type="checkbox"/>		Hotel, School, Hospital		
Blue <input type="checkbox"/>	Colour <input type="checkbox"/>		Red, Green, Blue		
Dog <input type="checkbox"/>	Animal <input type="checkbox"/>		Dog, Cat, Mouse		

Physical assessment - Date:					
Affected Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>			Dominant hand: Left <input type="checkbox"/> Right <input type="checkbox"/> Ambidextrous <input type="checkbox"/>		
Pre-morbid Upper limb changes (oedema / subluxation / arthritis / dysfunction / pain)					

Pre-morbid Lower limb changes (oedema / arthritis / dysfunction / pain)					

Tonal changes - Date:					
UL Tone (general comments):					

LL Tone (general comments):					

(if further info required add to separate 33ab form)					

UL Sensation / Proprioception		LL Sensation	
Light touch:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>	Light touch:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>
Deep touch:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>	Deep touch:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>
Sharp / Dull:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>	Sharp / Dull:	Intact <input type="checkbox"/> Impaired <input type="checkbox"/>

UL Proprioception		LL Proprioception	
Thumb ____ /6 screen		Ankle ____ /6 screen	
Further joints if impaired:		Further joints if impaired:	
_____		_____	
_____		_____	
Stereognosis: Intact <input type="checkbox"/> Impaired <input type="checkbox"/>			
Unaffected side: Intact <input type="checkbox"/> Impaired <input type="checkbox"/>			

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Coordination – Date:

Dysmetria (Finger - nose - finger):	Present <input type="checkbox"/>	Absent <input type="checkbox"/>
Dysdiadochokinesia (Pronation - supination):	Present <input type="checkbox"/>	Absent <input type="checkbox"/>
Opposition:	Intact <input type="checkbox"/>	Impaired <input type="checkbox"/>
In-hand Manipulation:	Intact <input type="checkbox"/>	Impaired <input type="checkbox"/>
Heel - shin:	Intact <input type="checkbox"/>	Impaired <input type="checkbox"/>
Foot tapping:	Intact <input type="checkbox"/>	Impaired <input type="checkbox"/>

Grip strength – Date:	Right	kg	Left	kg
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Functional observations - Date:
Comb hair (*Strength and AROM, praxis, form constancy, object recognition, spatial awareness, figure ground*):Manipulation of knife and fork (*Shoulder flex and internal rotation, elbow flexion, pronation, wrist flexion and extension finger flexion*):Do up/undo button (*Shoulder flex, internal rotation, elbow flexion, wrist flexion, fine motor finger control*)
Summary of upper limb findings (AROM; PROM; Strength; Abnormal patterns of movement; Abormal postures)
LINE DRAWING (MMAS)
DOTS / DRAWING

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MOTOR ASSESSMENT SCALE

	ADM	/ /	/ /	D/C
SUPINE → SIDE LIE	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
SUPINE TO SIT	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
BALANCED SITTING	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
SIT TO STAND	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
WALKING	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
UPPER ARM FUNCTION	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
HAND MOVEMENTS	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
ADVANCED HAND ACTIVITIES	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Initial				

Functional mobility

MOBILITY SCALE FOR ACUTE STROKE PATIENTS (MSAS)

	ADM	/ /	/ /	D/C
1. Bridging from supine (clearing buttocks off bed)				
2. Supine → SOEOB → Supine				
3. Balanced sitting for 3mins with max. BOS				
4. Sit → Stand				
5. Balanced standing for 1min				
6. Gait +/- aid indoors, flat				
Initial				

BALANCE AND GAIT ASSESSMENT

	ADM	/ /	/ /	D/C
Organisation Test: Wide stance (10cm apart) Narrow Stance Tandem (L) foot behind / (R) SLS: (L) / (R) foot	/	/	/	/
Step Test: (L) stance Leg / (R) stance Leg	/	/	/	/
Functional Reach				
Gait aid				
Timed Up & Go Test				
Timed 10m walk: Comfortable Pace Fast Pace				
Other:				
Initial				



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Attention: Focused Intact Impaired **Sustained** Intact Impaired

Divided Intact Impaired

Ability to follow commands:

Insight/Judgment/Reasoning:

Why are you in hospital?

What problems do you have now (that you did not have before you came into hospital)?

How would these problems change your ability to:

1. Drive a car?
2. Get to the toilet?
3. Cook dinner?

Planning and sequencing: Can you tell me the steps you need to do when making a cup of tea or coffee (roughly 4-5 steps)?

- 1.
- 2.
- 3.
- 4.
- 5.

Problem solving:

You realise on your way home from the shops that you have lost your purse/wallet. What will you do?

Behavioural Observation:

Perception - Date:

Praxis: (Please comment from information gathered functional observations and writing tasks)

Ideational: Intact Impaired **Ideomotor:** Intact Impaired

Spatial awareness (Position in Space):

On top Beneath In front Behind Near/far

Body schema: Left knee Right hand Right shoulder Left ear

Right/Left discrimination: Intact Impaired

Object agnosia: (Identify pen from 3 other familiar objects placed on table) Intact Impaired

Figure ground: Intact Impaired

Draw a clock (Spatial awareness, planning, sequencing):

Write Name: _____

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Screening for Unilateral Spatial Neglect (USN):

Bilateral Extinction	
Reading	
Scanning room	
Mobility	
Head posture/midline shift	

Summary of cognitive and perceptual finding:Further cognitive or perceptual assessment indicated Yes No

	Nutrition and Dietetics	Initial	Date
Assessment	Weight and height recorded Weight _____ Height _____ Weight in past month <input type="checkbox"/> No change <input type="checkbox"/> Increased _____ <input type="checkbox"/> Decreased _____		
	Screened for malnutrition <input type="checkbox"/> At risk MST score _____ <input type="checkbox"/> Not at risk PG-SGA score _____		
Intervention	Implemented food charts to monitor oral intake Initiated intervention to improve/maintain nutrition status <input type="checkbox"/> Nutritional supplementation <input type="checkbox"/> Enteral nutrition		
Education	Identified modifiable risk factors <input type="checkbox"/> High cholesterol/triglycerides <input type="checkbox"/> High blood pressure <input type="checkbox"/> Overweight/obesity <input type="checkbox"/> Diabetes		
	Educated on dietary changes for stroke prevention <input type="checkbox"/> Maintain a healthy weight, if overweight aim to lose weight gradually <input type="checkbox"/> Cut back on fat, particularly saturated fat <input type="checkbox"/> Regularly eat foods containing Omega-3 fats <input type="checkbox"/> Reduce salt intake <input type="checkbox"/> Consume adequate amounts of fruit, vegetables and low fat dairy <input type="checkbox"/> Limit alcohol intake		

KEY:	3M	Moist Minced Mashed	6/24	Every Six Hours	8/24	Every Eight Hours
	ACAT	Aged Care Assessment	AMI	Acute Myocardial Infarction	BOS	Base Of Support
	BP	Blood Pressure	BSL	Blood Sugar Level	CACP	Community Aged Care Package
	CDT	Community Dementia Team	CHNS	Community Health Nursing Service	CNC	Clinical Nurse Consultant
	COAGS	Coagulation Rate	COS	Community Options Service	COSNESB	Community Option Service Non English Speaking Background
	CT SCAN	Computed Tomography Scan	DEM	Department Of Emergency Medicine	DVA	Department Of Veterans Affairs
	ECG	Electrocardiogram	FBC	Fluid Balance Chart	GP	General Practitioner
	GTN	Glycerol Trinitrate	HACC	Home And Community Care	ICU	Intensive Care Unit
	IDC	Indwelling Catheter	IMI	Intramuscular Injection	INR	International Normalised Ratio
	IV	Intravenous	L	Left	LL	Lower Limb
	MAC	My Aged Care	MAIB	Motor Accident Insurance Board	MCA	Middle Cerebral Artery
	MOW	Meals On Wheels	MSAS	Mobility Scale Acute Stroke	NBM	Nil By Mouth
	NIHSS	National Institute Of Health Stroke Scale	NWD	Normal Ward Diet	O₂	Oxygen
	Obs	Observations	R	Right	R/V	Review
	SAH	Sub Arachnoid Haemorrhage	SCD	Sequential Compression Device	SOEOB	Sat On Edge Of Bed
	SLS	Single Leg Stance	SPC	Suprapubic Catheter	TPR	Temperature Pulse And Respirations
	TIA	Trans Ischaemic Attack	UE	Urea And Electrolytes	UL	Upper Limb

of plan	Day 3: Evaluation and revision of plan Date:	Day 4: Evaluation and revision of plan Date:	Day 5: Evaluation and revision of plan Date:
Yes <input type="checkbox"/>	Discharge plan reviewed: Yes <input type="checkbox"/> Referrals:	Discharge plan reviewed: Yes <input type="checkbox"/> Referrals:	Discharge plan reviewed: Yes <input type="checkbox"/> Referrals:
Initial	Initial	Initial	Initial
Time	Time	Time	Time
	Neuro obs 12/24 <input type="checkbox"/> TPR <input type="checkbox"/> BGL QID <input type="checkbox"/>	Obs 6/24	Obs 6/24
	R/V Arm Management Plan Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> C <input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/>	R/V Arm Management Plan Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> C <input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/>	R/V Arm Management Plan Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> C <input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/>
	Food chart <input type="checkbox"/> Yes		
	Yes <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(V if Yes)	(V if Yes)	(V if Yes)

