MMC ISCHEMIC MILD-MODERATE STROKE/TIA PATHWAY

	0-1 hour (ED)	1- 24 hours (stroke unit)	24-72 hours (stroke unit)
Assessment	Vital signs and neuro checks q 15-30 min Pre-stroke modified Rankin Score (mRS) Admission NIHSS Dysphagia screen prior to ANY po intake - Strict NPO & IVF with 0.9%NS for those who fail, followed by formal Speech Pathology consult - Cardiac/vegetarian diet for those who pass	Vital signs and neuro checks q4 hours Telemetry FSBG monitoring bid – qid as needed Repeat NIHSS	Vital signs and neuro checks q4 hours Telemetry FSBG monitoring bid – qid as needed mRS and NIHSS on day of discharge
Diagnostics	Labs (FSBG, CBC, BMP, PT/INR, Troponin, U/A) Head CT and CTA +/- CTP[1] ECG +/- CXR[2]	MRI brain[3] TTE with bubble study[4] Fasting lipid panel Fasting blood glucose (FBG) & HbA1c if FBG elevated Additional testing for unusual strokes or stroke in the young	TEE in select patients[5] Arrange for outpatient cardiac event monitor [6] if indicated
Consults	Neurology	Physical Therapy, Occupational Therapy Speech Pathologist for anyone who fails dysphagia screen - Adjust diet orders per their recommendations Physiatry Smoking cessation counseling if needed Nutrition consult if needed Palliative care and/or pastoral care if needed	Vascular surgery or Vascular Neurosurgery if the patient is a candidate for CEA/carotid stenting GI consult for PEG tube placement as needed
Interventions	Aspirin (given PR if patient fails dysphagia screen) Add clopidogrel for high-risk TIA/minor stroke or symptomatic atherosclerotic vascular disease Hold oral anticoagulation in the acute phase Statin as soon as oral route established Hold BP lowering agents in the acute phase* Do not treat BP in acute stroke unless > 220/120, unless there is another compelling reason to do so (ex: acute MI, aortic dissection) Use Ischemic Stroke admission order set Admit patient to Stroke Unit on telemetry *continue low-dose beta-blocker in pts in AF or heart failure	Continue aspirin +/- clopidogrel Continue statin Do not tx BP unless > 220/120 x 24-48h for most patients Hold/do not start anticoagulation for most patients DVT prophylaxis Nicotine replacement if needed D/c Foley if in place Increase activity as tolerated Elevate paretic limb, frequent turning and monitoring of bed sores, heel protectors/boots for paretic ankles Keep T < 38.0 with acetaminophen and surface cooling Aspiration precautions and oral hygiene Fall precautions as needed	Initiation of, or plan for initiation of, anticoagulation for patients with an indication for it Initiation of low-dose oral antihypertensives with gradual titration to control BP Provide stroke education Contact acute rehab if indicated
Discharge planning	Note if pt has lack of insurance to notify social work to being the application process	Assessment of need for rehabilitation by PT/OT/ST+/- physiatry Care Coordination begins discharge planning	Assess home care needs Contact acute rehab if needed Follow-up arranged with PCP, neurologist, any other provider needed

1. **CTP** = CT perfusion only indicated for patients with a large artery occlusion on CTA who are candidates for endovascular therapy; 2. **CXR** only for patients with symptoms of acute pulmonary or cardiac disease; 3. **MRI** brain not needed in patients with known cause of stroke and stroke already well visualized on head CT; MRA only if CTA not done in ED & carotid U/S only if CTA and MRA contraindicated; 4. **TTE** is not indicated if the patient already has an indication or a contraindication for long-term oral anticoagulation as it will not change management; 5. **TEE** should be done urgently in patients suspected of having infectious endocarditis or aortic dissection not diagnosed by other means, or subacutely in patients with a high-likelihood of cardioembolic stroke in whom TTE was non-diagnostic (can be done as an outpatient in some cases); 6. **Prolonged cardiac monitoring as an outpatient** is indicated for patients with high likelihood of afib (older age, acute embolic appearing strokes, prior embolic appearing stroke(s) on imaging, dilated left atrium TTE, etc.)