TEACH, LEARN, COLLABORATE

FOCUS 2015

Improving the Transitions of Care

An Evidence Based Medicine Approach
CHF, COPD and Stroke

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Case Study: Mary J.

- A 72 year old white female with a past medical history significant for atrial fibrillation, congestive heart failure, and multiple cardiac arrests presents to the ED on day 5 of her skilled nursing stay after being found unresponsive.
- On arrival to the ED her BP is 80/40mmHg, her HR is 160bpm and irregular and she is 88% saturated on 100% face mask.

On Admission…

Day 1 - Thursday

Day 1 18:49 Skilled Nursing Note

- Patient admitted from hospital via stretcher. Patient is 72 year old white female who is s/p exacerbation of CHF secondary to an MI. She is alert and oriented X3. She denies pain at this time. She denies SOB. No distress noted. Her BP is 140/74, HR 87. Oxygen at 2L via nasal cannula. Pulse ox 95%. 16FR foley draining light yellow urine. Lung sounds are clear. ABD round non-tender non-distended. Bowel sounds present x4 normal. Mild non-pitting edema noted to BLE which resolves when feet elevated in bed. Admission weight is 129lbs.

Day 2 - Friday

Day 2 03:37 Skilled Nursing Note

- Resident alert, oriented x3. Resting in bed. Admission orders reviewed with doctor. No new orders. Oxygen at 4 liters per n/c. Foley cath patent, urine clear, yellow. Resident took all meds well, fluids taken well. Denies pain, discomfort, has prn. Call bell within reach.

Day 2 15:19 General Progress Note

- VS 154/78,88,98.0,92% on 4l/nc. Pt stated that her pain was managed throughout shift. All meds & tx tolerated.

Day 2 21:29 General Progress Note

- VS 140,88,98.0,95%. Alert and oriented x3. Able to make needs known. Assist x1 with adl's. Foley patent draining clear yellow urine. Voices no c/o at this time.

Day 3 - Saturday

Day 3 15:54 General Progress Note

- Pt c/o of increased fatigue and SOB after therapy. Patient returned to bed. VS 148/73,80,98.4, 90% on 4l/nc. Physician notified. Order additional dose of Lasix 40mg x1 now and increased Lasix to 40mg p.o. BID.

Day 3 17:29 General Progress Note

- Pt's daughter in to visit and updated on pt's condition. Pt reports that she is feeling better after resting but she is not hungry and has refused her evening meal. Daughter asked when the doctor would be in to see her mother and was told that he normally rounds on Tuesdays. Daughter asked that the doctor call her.

Day 4 - Sunday

Day 4 07:53 Weekly Weight Note
Weekly weights noted at 135.2lbs. Will review with weight team.

Day 4 14:53 Skilled Nursing Note

- Patient ate 50% of her meals today and refused therapy. VS 110/82, 92, 98.4, 90%. She appears comfortable but says she feels like she is getting a cold. Resp even and unlabored. O2 per NC. No respiratory distress noted. Pt showered today. Daughter updated.

Day 5 - Monday

Day 5 00:07 Skilled Nursing Note

- Patient alert, oriented x3, sitting up in chair without complaint of pain/discomfort. Foley draining yellow urine.

Day 5 07:48 General Progress Note

- Foley cath d/c'd, tol. well. Color of urine in bag looked somewhat orange, clear. No c/o discomfort.

Day 5 13:57 Skilled Nursing Note

- Pt remained very lethargic throughout am. Pt stated she was very tired. Pt looked very pallor. Pt 02 stats were 80-85%, Pt breathing was labored, Lungs sound were congested with high pitched rhonchi upon expiration. Pt. expressed that she had chest tightness & congestion & that she was very thirsty. Glucose level was WNL. Patient became increasingly less responsive. MD was called with symptoms & overall update on Pt, Orders were given to send pt to ER. Family was notified.

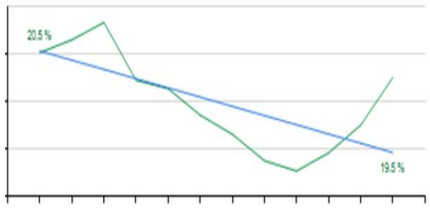
DAY 5: 9:15pm

- A 72 year old white female with a past medical history significant for atrial fibrillation, congestive heart failure, and multiple cardiac arrests presents to the ED on day 3 of her skilled nursing stay after being found unresponsive.
- On arrival to the ED her BP is 80/40mmHg, her HR is 160bpm and irregular and she is 88% saturated on 100% face mask.

Preventable?

Studies on Rehospitalization

- Within 30 days of hospitalization 23.5% of all SNF Medicare beneficiaries are rehospitalized.
- 90% of rehospitalizations within 30 days appear to be unplanned, the result of clinical deterioration.
- MedPAC estimates that up to 76 percent of those re-hospitalizations may be preventable, representing a potential savings to Medicare of over $12 billion in one year
- Only half of the patients rehospitalized within 30 days had a physician visit before readmission.
- Of the Medicare beneficiaries who are re-hospitalized within 30 days, 64% receive no post-acute care between discharge and readmission.
- 19% of Medicare discharges are followed by a “preventable” adverse event within 30 days—2/3 are medication related.



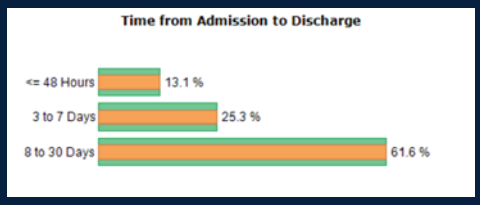
The NEW Quality Measure

Why Do Patients Get Stuck in the Revolving Door of HealthCare?

Rehospitalization Prevention Opportunities

- At 24-48 Hours
  - Transition of Care
- At Day 3-7
  - Initial Assessment
- At Day 8-30
  - Communication

30 Day Thresholds

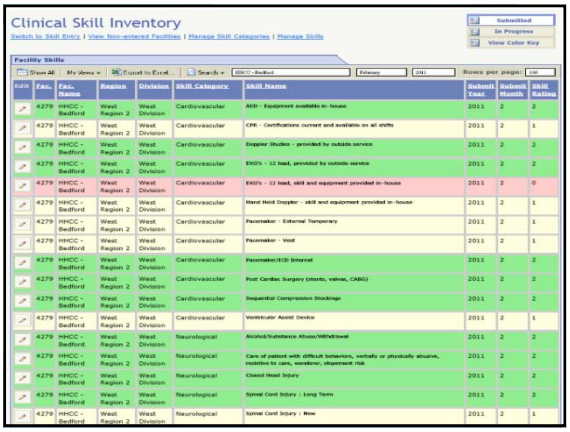


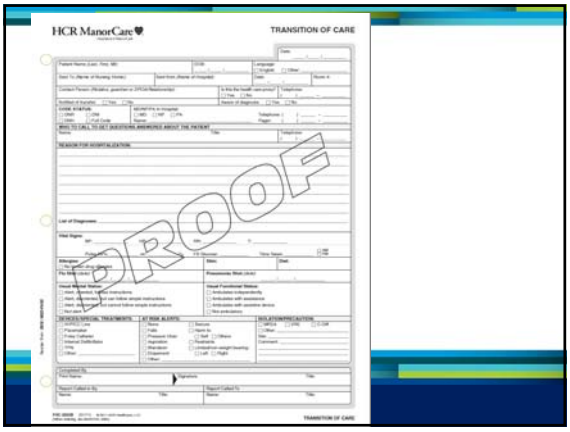
Rehospitalization Prevention Initiatives

- At 24-48 Hours
  - Transition of Care
- At Day 3-7
  - Initial Assessment
- At Day 8-30
  - Communication

Transition of Care Initiatives
24-48 Hours - Transition

- Clinical Skills Inventory
- Transition of Care Nurse to Nurse Report





Transition of Care Initiatives
3-7 Days - Medical Practice

- ❑Initial Visit Window
- ❑Frequency of Visits
- ❑Individualized Diagnosis Specific Treatment Protocols

Rehospitalization from PAC
Patient Diagnostic Profile - 2014

- **78 year old white female**
  - **Primary Reason for Rehospitalization Diagnosis:**
    - **Cardiac – 28%**
    - **Pulmonary – 24%**
    - **Neurologic – 17%**
    - **Fever – 12%**
    - **Gastrointestinal – 8%**
    - **Orthopedic – 8%**
    - **Other – 3%**

Evidenced-Based
Diagnosis Specific Protocols

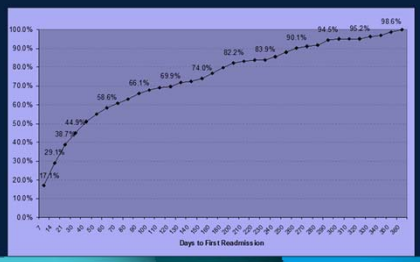
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Cerebrovascular Accidents

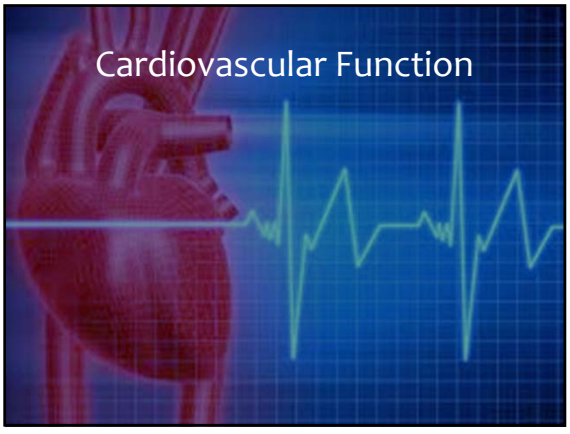
Heart Failure

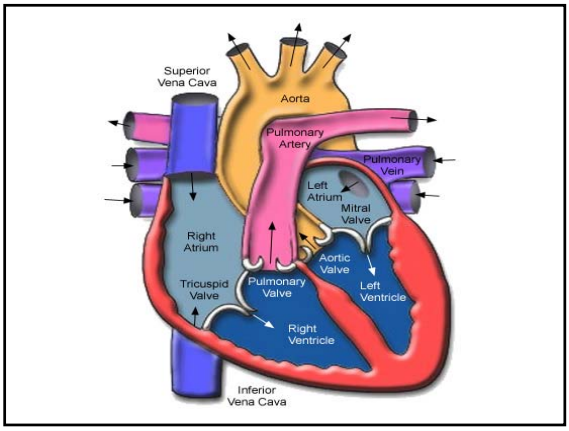
- Fastest growing clinical cardiac disease in the United States.
- Approximately 670,000 new cases of heart failure are diagnosed each year
- About 277,000 deaths are attributed to heart failure each year
- The most frequent cause of hospitalization in patients over 65 years

Risk of CHF Rehospitalization

It's Just a Matter of Time

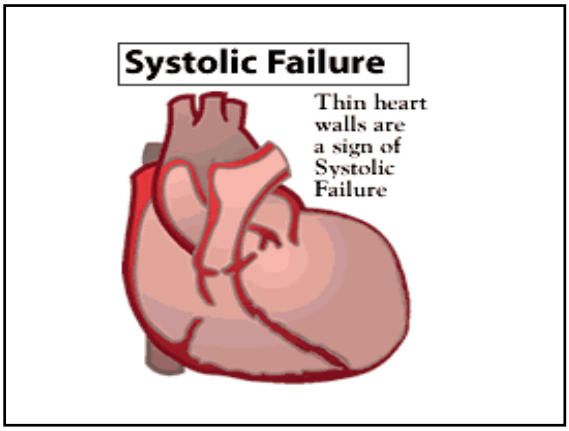






Anatomy of Ventricular Failure

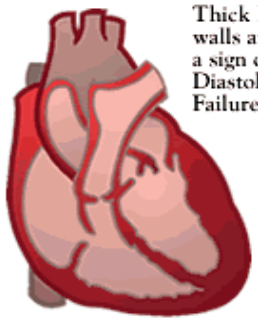
- *Systolic failure*: causes ventricle not to empty properly (most common cause of CHF)
  - Heart muscle has decreased ability to contract
  - Also caused by increased afterload (hypertension), or mechanical abnormalities (like valvular heart disease)
  - Characterized by low forward blood flow



Anatomy of Ventricular Failure

- *Diastolic failure*: causes ventricle not to fill properly
  - Disorder of heart relaxation and ventricular filling
  - Usually the result of ventricular hypertrophy
  - Caused by chronic hypertension, aortic stenosis, or cardiomyopathy
  - Commonly seen in older adults

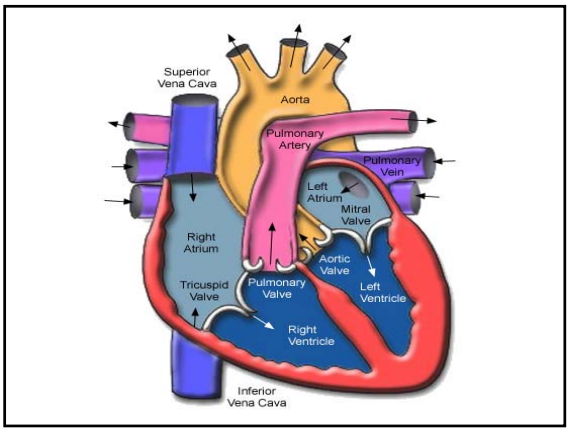
Diastolic Failure



Thick heart walls are a sign of Diastolic Failure

Types of CHF

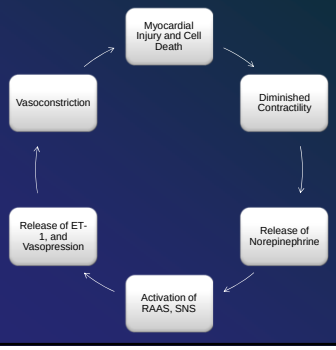
- Left sided failure
  - Back up of blood into the lungs
  - Common causes are: CAD, HTN, cardiomyopathy and rheumatic heart disease
  - Other causes can be: MI damage, ischemia, scar tissue (reducing contractility),



Types of CHF

- Right sided failure
  - Backup of blood into the venous system and right side of the heart
  - Primary cause is left sided failure
  - Also caused by Cor pulmonale (caused by COPD, and pulmonary emboli)
  - Also caused by MI damage, ischemia and scarring

Pathophysiology of HF



Neurohormonal Effects in HF

Response	Short-Term Effects*	Long Term Effects
Salt and water retention	Augments preload to increase cardiac output	Pulmonary congestion and peripheral edema
Vasoconstriction	Maintains blood pressure for perfusion of vital organs	Exacerbates pump dysfunction (increased cardiac afterload and energy expenditure)
Sympathetic stimulation	Increases heart rate and ejection (increased output)	Increases energy expenditure and causes arrhythmias
Cardiac hypertrophy	Adaptive: increased sarcomere number with increased cardiac output	Maladaptive: accelerated cell death, arrhythmias

Table 1. Homeostatic Responses to Impaired Cardiac Performance (Due in part to activation of the renin-angiotensin-aldosterone system (RAAS) and of the sympathetic nervous system).

Signs and Symptoms

- Angina
- Tachycardia
  - Palpitations
- Venous Congestion
  - Edema, Orthopnea
- Low Cardiac Output
  - Dyspnea
  - Fatigue
  - Decreased Appetite
  - Nocturia or Oliguria
  - Cerebral Symptoms

Transitions of Care Initiatives
Heart Failure

24-48 Hours Checklist

- ☐ Low Salt Diet
- ☐ Daily Weights
- ☐ Baseline Vital Signs
  - ☐ Orthostatic Blood Pressure and Heart Rate
  - ☐ Oxygen Saturation
- ☐ Baseline Cardiac Labs
  - ☐ BNP
  - ☐ Glucose
  - ☐ K, BUN, CRT
- ☐ Cardiac Medication Review
  - ☐ Loop Diuretics
  - ☐ Digoxin
  - ☐ ACE-I
  - ☐ B-blocker
  - ☐ Spirinolactone
  - ☐ Alternate Cardiac Medications

ACE-I in CHF

- Mainstay of CHF Therapy
  - Improves Survivability
  - Decreases Disease Progression
  - Decreases CHF Readmissions
- Weekly Titration to Maximize Benefit
  - 'Start low and go slow'
  - Titrate Ace-I, wean diuretic
- Monitor Labs and Side Effects

CHF – ACE-I Dosing Schedule

Drug	Initial dosage (mg)	Targeted dosage	Maximal dosage	Peak BP effect
Captopril (Capoten)	6.25 to 12.5	50 mg three times daily	100 mg three times daily	1 to 2 hours
Enalapril (Vasotec)	2.5 to 5	10 mg twice daily	20 mg twice daily	4 to 6 hours
Fosinopril sodium (Monopril)	5 to 10	20 mg daily	40 mg daily	2 to 6 hours
Lisinopril (Zestril)	2.5 to 5	20 mg twice daily	40 mg twice daily	2 to 6 hours
Quinapril (Accupril)	5 to 10	20 mg twice daily	40 mg twice daily	2 to 4 hours
Ramipril (Altace)	1.25 to 2.5	5 mg twice daily	10 mg twice daily	4 to 6 hours

CHF – Cardiac Medication Review Evidence Based Approach

- ❑ Loop Diuretics (NYHA II, III, IV)
- ❑ Digoxin (Variable evidence)
- ❑ ACE-I (Strong evidence)
- ❑ ARBs (Limited evidence)
- ❑ B-Blockers (NYHA II, III)
- ❑ Spirinolactone (RALES)
- ❑ NSAIDS (negative effect)
- ❑ Calcium Channel Blockers (PRASES)

Transitions of Care Initiatives
Heart Failure

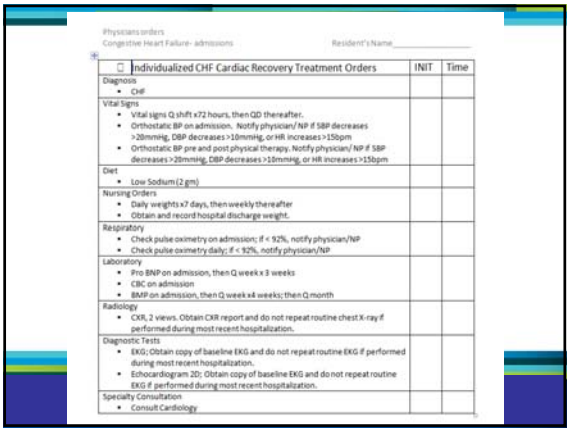
Ongoing Assessment

- ☐ History
  - ☐ NYHA Functional Classification
  - ☐ Angina
  - ☐ Cough
- ☐ Physical Examination
  - ☐ Low SBP
  - ☐ Edema
- ☐ Database
  - ☐ Anemia
  - ☐ CRT
  - ☐ Echocardiogram

New York Heart Association (NYHA) Classification of Heart Failure

Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary physical activity results in fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).
Class IV (Severe)	Unable to carry on physical activity without discomfort. Symptoms of fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea) are present at rest. If any physical activity is undertaken, discomfort increases.

Transitions of Care Initiatives
Heart Failure

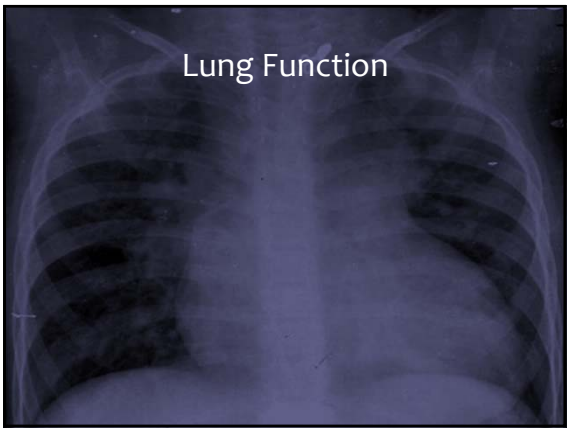


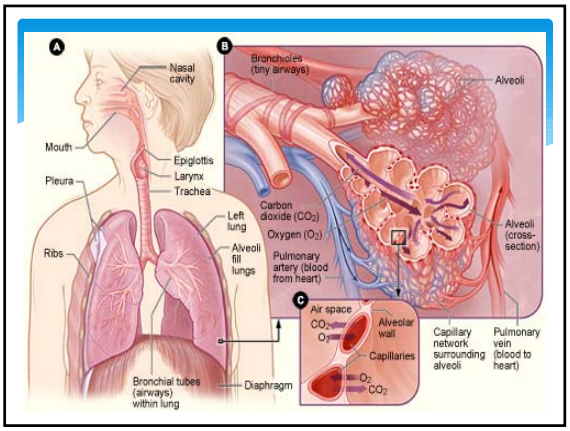
Physicians orders
Congestive Heart Failure- admissions
Resident's Name_____

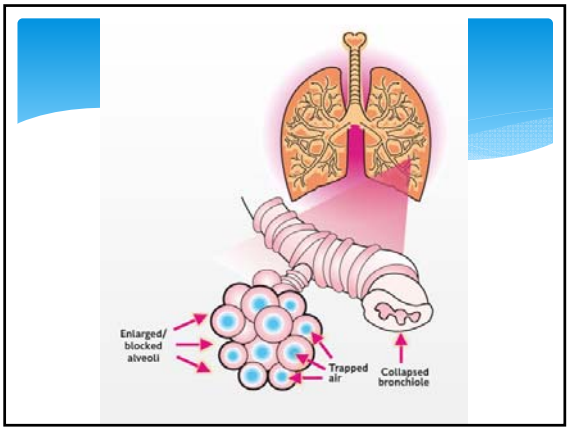
☐ Individualized CHF Cardiac Recovery Treatment Orders	INIT	Time
Diagnosis • CHF		
Vital Signs • Vital signs Q shift x72 hours, then QD thereafter. • Orthostatic BP on admission. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm • Orthostatic BP pre and post physical therapy. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm		
Diet • Low Sodium (2 gm)		
Nursing Orders • Daily weights x7 days, then weekly thereafter • Obtain and record hospital discharge weight.		
Respiratory • Check pulse oximetry on admission; if < 92%, notify physician/NP • Check pulse oximetry daily; if < 92%, notify physician/NP		
Laboratory • Pro BNP on admission, then Q week x 3 weeks • CBC on admission • BMP on admission, then Q week x4 weeks; then Q month		
Radiology • CXR, 2 views. Obtain CXR report and do not repeat routine chest X-ray if performed during most recent hospitalization.		
Diagnostic Tests • EKG; Obtain copy of baseline EKG and do not repeat routine EKG if performed during most recent hospitalization. • Echocardiogram 2D; Obtain copy of baseline EKG and do not repeat routine EKG if performed during most recent hospitalization.		
Specialty Consultation • Consult Cardiology		

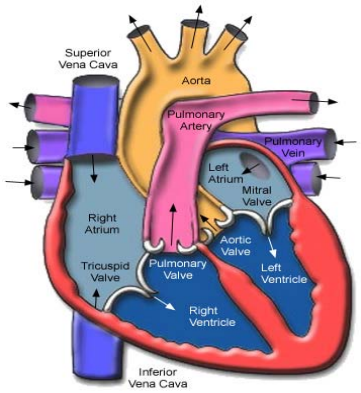
COPD

- Third leading cause of death in the United States.
- The most underdiagnosed and undertreated disease process in the world.
- Second leading cause of disability. Approximately 32 Million individuals in the United States claim disability secondary to COPD
- The third most frequent cause of 30 day rehospitalizations


Lung Function


A
B
C
Nasal cavity
Mouth
Epiglottis
Larynx
Trachea
Pleura
Ribs
Left lung
Alveoli fill lungs
Bronchial tubes (airways) within lung
Diaphragm
Bronchioles (tiny airways)
Alveoli
Carbon dioxide (CO_2)
Oxygen (O_2)
Pulmonary artery (blood from heart)
Alveoli (cross-section)
Air space
CO_2
O_2
Alveolar wall
Capillaries
Capillary network surrounding alveoli
Pulmonary vein (blood to heart)
O_2
CO_2


Enlarged/ blocked alveoli
Trapped air
Collapsed bronchiole



Types of CHF

- Right sided failure
  - Backup of blood into the venous system and right side of the heart
  - Primary cause is left sided failure
  - Also caused by Cor pulmonale (caused by COPD, and pulmonary emboli)
  - Also caused by MI damage, ischemia and scarring

Transition of Care Initiatives
COPD

24-48 Hour Checklist

- ❑ 2G Na Diet
- ❑ Vital Sign Parameters
- ❑ Database
  - ❑ ABG
  - ❑ CBC
  - ❑ Chem 7
- ❑ COPD Medication Review
  - ❑ Steroid Therapy
  - ❑ Long Acting B2 Adrenergic Agonist
  - ❑ Short Acting B2 Adrenergic Agonist
  - ❑ Long Acting Anti-cholinergic
  - ❑ Short Acting Anticholinergic
  - ❑ Phosphodiesterase type 4 Inhibiitor
  - ❑ Leukotriene Receptor Antagonist
  - ❑ Antibiotics

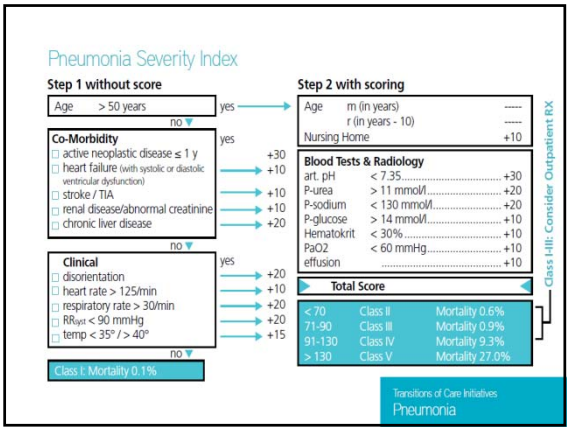
COPD Medication Review Evidence Based Approach

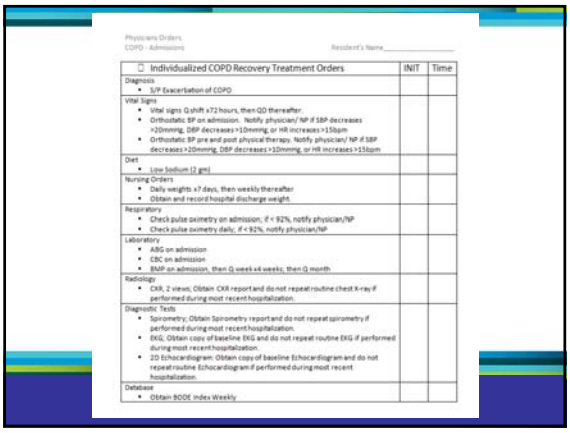
- Corticosteroid (Strong Evidence)
- a long acting B2 adrenergic agonist (Salmeterol)
- a short acting B2 agonist (Albuterol)
- A long acting anticholinergic – (Tiotropium -Spiriva) decrease airway tone and increase airflow
- A short acting anticholinergic – (Ipratropium-Atrovent)
- Phosphodiesterase type 4 inhibitor (PDE4) an immune cell mediator antiinflammatory (Variable Evidence)(Roflumilast -Daliresp)
- Antibiotics (Strong evidence)

Transition of Care Initiatives
COPD

Ongoing Assessment

- History
  - Risk factors
  - Associated morbidities
- Physical Examination
  - Pneumonia Severity Index
- Database
  - Spirometry
  - Sputum Culture
- COPD Medication Review
  - DVT Prophylaxis





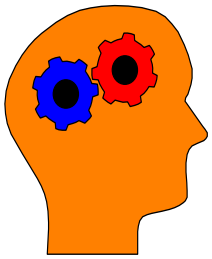
Physicians Orders
COPD - Admissions

Resident's Name_____

☐ Individualized COPD Recovery Treatment Orders	INIT	Time
Diagnosis • S/P Exacerbation of COPD		
Vital Signs • Vital signs Q shift x72 hours, then QD thereafter • Orthostatic BP on admission. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm • Orthostatic BP pre and post physical therapy. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm		
Diet • Low Sodium (2 gm)		
Nursing Orders • Daily weights x7 days, then weekly thereafter • Obtain and record hospital discharge weight.		
Respiratory • Check pulse oximetry on admission; if < 92%, notify physician/NP • Check pulse oximetry daily; if < 92%, notify physician/NP		
Laboratory • ABG on admission • CBC on admission • BMP on admission, then Q week x4 weeks; then Q month		
Radiology • CXR, 2 views; Obtain CXR report and do not repeat routine chest X-ray if performed during most recent hospitalization.		
Diagnostic Tests • Spirometry; Obtain Spirometry report and do not repeat spirometry if performed during most recent hospitalization. • EKG; Obtain copy of baseline EKG and do not repeat routine EKG if performed during most recent hospitalization. • 2D Echocardiogram: Obtain copy of baseline Echocardiogram and do not repeat routine Echocardiogram if performed during most recent hospitalization.		
Database • Obtain BODE Index Weekly		

Stroke

- Fourth most common cause of death
- Leading cause of neurologic disability
- Accounts for 50% of patients hospitalized with a neurologic disability
- Most common diagnostic impairment group in inpatient rehabilitation units
- Leading cause for admission to the nursing home or extended care facility



Stroke

A sudden onset of focal neurologic deficits due to the presumed local disturbance of blood supply to the brain

Pathogenesis

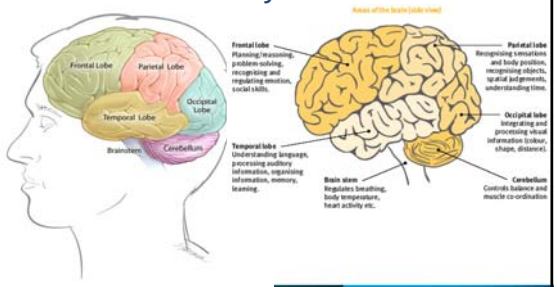
Thromboembolic

- Embolic
- Thrombotic
- Lacunar

Hemorrhagic

- Intracerebral
- Subarachnoid

Stroke Syndromes



Motor Impairments

- Motor Weakness - 90%
  - R Hemiparesis - 45%
  - L hemiparesis - 35%
  - B Hemiparesis - 10%
- Dysarthria - 50%
- Sensory Deficits - 50%
- Cognitive -35%
- Aphasia - 35%
- Depression - 30%
- Bladder incontinence - 30%
- Dysphagia - 30%
- Visuoperceptual deficits - 30%
- Hemianopsia - 25%
- Ataxia - 20%

Medical Post Stroke Complications

- Malnutrition
- Aspiration
- DVT
- Anxiety
- Depression
- Pneumonia
- Cardiac complications
- Sexual dysfunction
- Seizures
- Pressure ulcers
- Bowel and bladder dysfunction
- Falls

Transition of Care Initiatives
Stroke

24-48 Hour Checklist

- ❑ DASH Diet
- ❑ Vital Sign Parameters
- ❑ Database
  - ❑ CBC
  - ❑ Blood Glucose
  - ❑ Bladder Parameters
  - ❑ Venous Doppler
- ❑ Stroke Medication Review
  - ❑ Oxygen
  - ❑ B-Complex Vitamins
  - ❑ Antiaggregants - ASA
  - ❑ Anticoagulation
  - ❑ Anti-hypertensives
  - ❑ Cholesterol and Lipid lowering medications

Stroke Medication Review Evidence Based Approach

- ❑ B-Complex Vitamins (Limited evidence)
- ❑ Platelet Antiaggregants (Strong evidence)
  - ❑ ASA
  - ❑ Ticlopidine
  - ❑ Clopidogrel
  - ❑ Dyperidamole (ESPS-2 and ESPRIT)
- ❑ Anticoagulants (Variable evidence)
- ❑ HMG-CoA Reductase Inhibitors (Strong evidence)
- ❑ Antihypertensives (Strong evidence)
  - ❑ ACE-I

CHF – ACE-I Dosing Schedule

Drug	Initial dosage (mg)	Targeted dosage	Maximal dosage	Peak BP effect
Captopril (Capoten)	6.25 to 12.5	50 mg three times daily	100 mg three times daily	1 to 2 hours
Enalapril (Vasotec)	2.5 to 5	10 mg twice daily	20 mg twice daily	4 to 6 hours
Fosinopril sodium (Monopril)	5 to 10	20 mg daily	40 mg daily	2 to 6 hours
Lisinopril (Zestril)	2.5 to 5	20 mg twice daily	40 mg twice daily	2 to 6 hours
Quinapril (Accupril)	5 to 10	20 mg twice daily	40 mg twice daily	2 to 4 hours
Ramipril (Altace)	1.25 to 2.5	5 mg twice daily	10 mg twice daily	4 to 6 hours

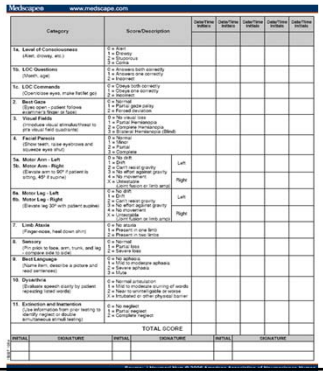
Transition of Care Initiatives
Stroke

Ongoing Assessment

- History
  - Risk factors
  - Associated morbidities
- Physical Examination
  - NIH Stroke Scale
  - Outcome Predictors
- Stroke Medication Review
  - DVT Prophylaxis
  - Neurostimulants
  - SSNRIs
  - Anticonvulsant Therapy
  - Antispasticity Agents
  - Bowel and Bladder Management
- Education

Transition of Care Initiatives
Stroke

NIH Stroke Scale


Medscape www.medscape.com

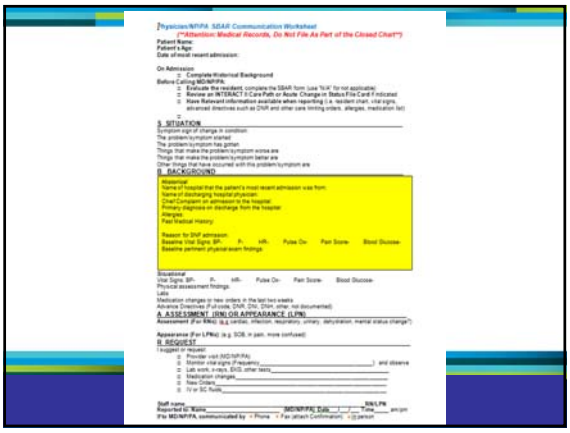
Category	Score/Description	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials
1a. Level of Consciousness (Alert, drowsy, etc.)	0 = Alert 1 = Drowsy 2 = Stupor 3 = Coma					
1b. LOC Questions (Month, age)	0 = Answers both correctly 1 = Answers one correctly 2 = Neither					
1c. LOC Commands (Open/close eyes, make fist/let go)	0 = Obeys both correctly 1 = Obeys one correctly 2 = Neither					
2. Best Gaze (Test horizontal – patient follows direction to finger or face)	0 = Normal 1 = Partial gaze palsy 2 = Forced deviation					
3. Visual Fields (Introduce visual stimulus/threat to intact field quadrants)	0 = No visual loss 1 = Partial hemianopsia 2 = Complete hemianopsia 3 = Bilateral hemianopsia (blind)					
4. Facial Palsy (Show teeth, raise eyebrows and squeeze eyes shut)	0 = Normal 1 = Minor 2 = Partial 3 = Complete					
5a. Motor Arm - Left 5b. Motor Arm - Right (Extends arm to 90° if patient is sitting, 45° if supine)	0 = No drift 1 = Drift 2 = Can't resist gravity 3 = No effort against gravity 4 = No movement X = Unknown (Arm flaccid or limb amputated)	Left Right				
6a. Motor Leg - Left 6b. Motor Leg - Right (Elevate leg 30° with patient supine)	0 = No drift 1 = Drift 2 = Can't resist gravity 3 = No effort against gravity 4 = No movement X = Unknown (Leg flaccid or limb amputated)	Left Right				
7. Limb Ataxia (Finger-nose, heel down shin)	0 = No ataxia 1 = Present in one limb 2 = Present in two limbs					
8. Sensory (Pin prick to face, arm, trunk, and leg (compare side to side))	0 = Normal 1 = Mild loss 2 = Severe loss					
9. Best Language (Name item, describe a picture and read sentences)	0 = No aphasia 1 = Mild-moderate aphasia 2 = Severe aphasia 3 = Mute					
10. Dysarthria (Evaluate speech clarity by patient repeating listed words)	0 = Normal articulation 1 = Mild to moderate slurring of words 2 = Severe slurring; unintelligible or worse X = Intubated or other physical barrier					
11. Extinction and Inattention (Use information from prior testing to identify neglect or double simultaneous stimuli testing)	0 = No neglect 1 = Partial neglect 2 = Complete neglect					
	TOTAL SCORE					
INITIALS / SIGNATURE	INITIALS / SIGNATURE	INITIALS / SIGNATURE				

Physicians Orders
Cerebral Vascular Accident- Admission
Resident's Name_____

Individualized Stroke Recovery Treatment Orders	INIT	Time
Diagnosis • S/P CVA		
Vital Signs • Vital signs Q shift x72 hours, then QD thereafter. • Notify physician/NP if SBP >140mmHg and/or DBP >90mmHg • Orthostatic BP on admission. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm • Orthostatic BP pre and post physical therapy. Notify physician/ NP if SBP decreases >20mmHg, DBP decreases >10mmHg, or HR increases >15bpm		
Diet • DASH Diet		
Nursing Orders • Obtain and record NIH Stroke Scale and repeat and record weekly. For patients without an indwelling foley catheter: • Check PVR bladder scan after each void. If PVR scan volume is >200cc, then straight catheterize. • If no void in 6 hours, check bladder scan. If volume >400ccs, straight catheterize and change frequency of bladder protocol to Q4 hours. If volume 200-400ccs, straight catheterize and continue Q6 hour bladder protocol. If bladder volume <200ccs, continue Q6 hour bladder protocol.		
Respiratory • Check pulse oximetry on admission; if < 92%, notify physician/NP • Check pulse oximetry daily; if < 92%, notify physician/NP		
Laboratory • CBC on admission • BMP on admission, then Q week x4 weeks; then Q month		
Radiology • Bilateral LE Venous Doppler Studies, R/O DVT		
Diagnostic Tests • EKG; Obtain copy of baseline EKG and do not repeat routine EKG if performed during most recent hospitalization.		

Transition of Care Initiatives
8-30 days - Communication

- ❑SBAR
- ❑Early Warning Sign and Symptoms
- ❑Critical Thinking Pathways

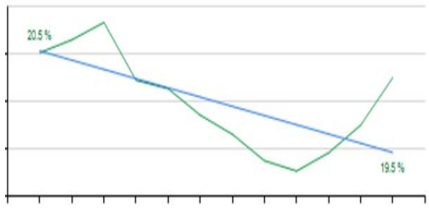


CNA Alerts

Quality Assessment and Performance Improvement

Quality Care Initiatives

- Clinical Skills Inventory.
- Transition of Care Nurse-to-Nurse Report.
- SBAR support.
- Individualized Diagnosis Specific Treatment Checklist and Protocols.
- Alert Review.
- Care Path Utilization.



The NEW Quality Measure