STROKE EDUCATION

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Sepsis/Stroke Coordinators

B.E.F.A.S.T TO SPOT A STROKE

- BALANCE- Loss of balance or dizziness
- EYES- Changes in vision
- FACE- Facial drooping
- ARMS- Weakness or numbness
- SPEECH- Trouble speaking
- TIME- Call a stroke alert (or 911) immediately

POST OPERATIVE CHANGES

- Anesthesia is required to sign out the patient prior to being discharged from the PACU
- Discharged can be admission or to home
- If patient exhibits signs/symptoms of stroke please call stroke alert
  - ie: slurred speech, change in mentation, weakness to one side of the body, facial droop
    - If any concerns please call anesthesia

TPA TO TNK CHANGE COMING DECEMBER 3

- The vial is a 50mg vial. When you add 10ml you will have a 5mg to 1ml dilution. The max dose is 25mg so you will always waste 5ml-Pull this first.
  - Bolus is given over 5 seconds

Prepare tenecteplase in designated clean area:

1. Remove shield assembly from supplied 10mL syringe.
2. Withdraw 10mL of Sterile Water using syringe with dual TwinPak cannula device.
3. Inject entire 10mL of Sterile Water into tenecteplase vial and directing towards the powder.
4. Gently swirl until completely dissolved. Color should be clear to pale yellow.

Independent Double Check with a RN or other verifier according to facility practice, to include:

- Ordered dose (Maximum dose is 25mg/5mL)
- Medication
- Patient weight
- Prepared dose
- Co-signer documents IDC in eMAR

- The calculation is 0.25mg X pts weight in kilograms-max dose 25mg
- The vital signs and neurochecks remains the same as with TPA so you can continue to use the sheet in the Yellow box.
- The yellow boxes will remain stocked because you may still need to give Cardene and other antihypertensives. There is no more infusion or a need to hang a 50ml NS bag

INPATIENT STROKE ALERT

- Know when the patient was last known to be "normal"
- Know if the patient is on blood thinners like Lovenox or Heparin SubQ, Eliquis etc.
- Blood glucose ASAP
- Vital Signs ASAP
- New Weight ASAP
- NIH by the Provider (nurse or practitioner)
- GET TO CT ASAP order STROKE BRAIN
- Teleneuro consult entered through the E-alert system on the Microsoft edge browser and through the PWH homepage
  - Only the ER cart can be used for stroke alerts
    - The cart in the 911 is for rounding and Stat consults only
- You must redo a dysphasia screen immediately upon returning to the unit.

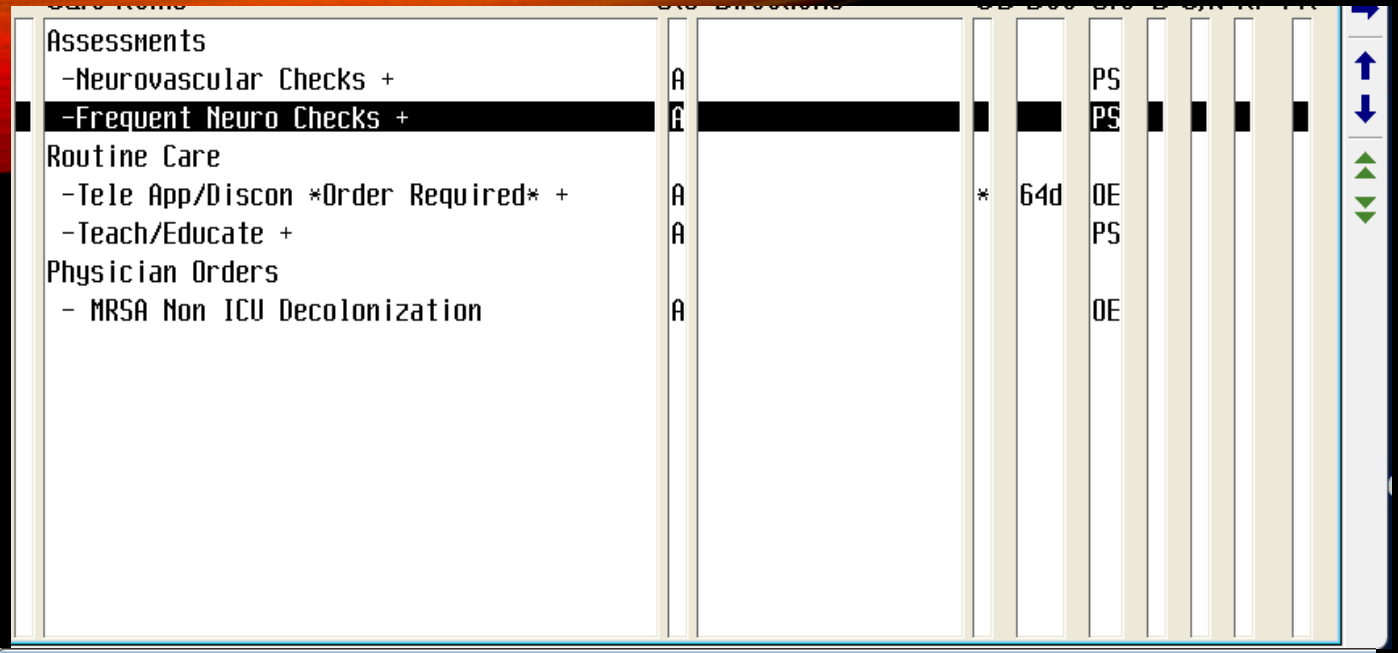
NIH STROKE SCALE

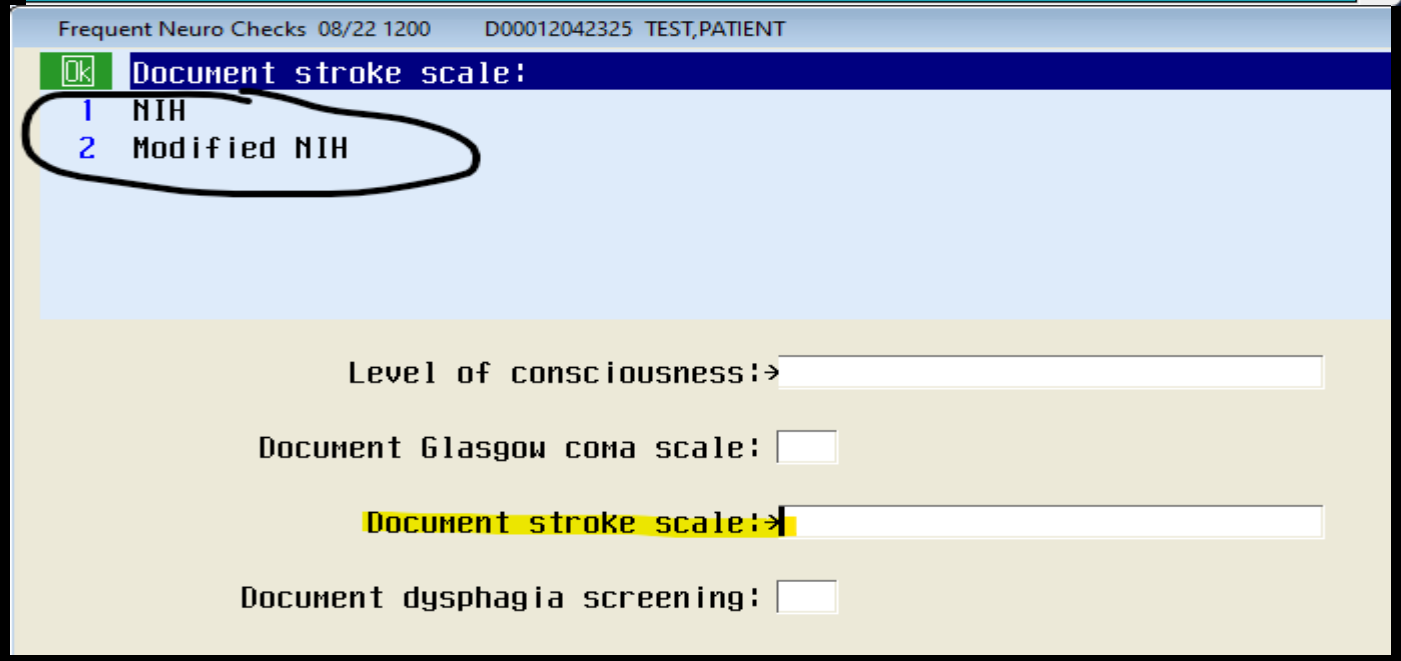
- NIH must be done on arrival for ALL patients (to the ER or the unit) with any neurological symptoms. For example: dizziness, headache, weakness, AMS, vertigo, visual changes, encephalopathy, Bell's palsy, or numbness and tingling to the extremities.

- An NIH must be completed once a shift on all R/O or confirmed Stroke patients and TIA's.

- And it must be redone immediately for any change in neuro status.

FREQUENT NEURO CHECKS



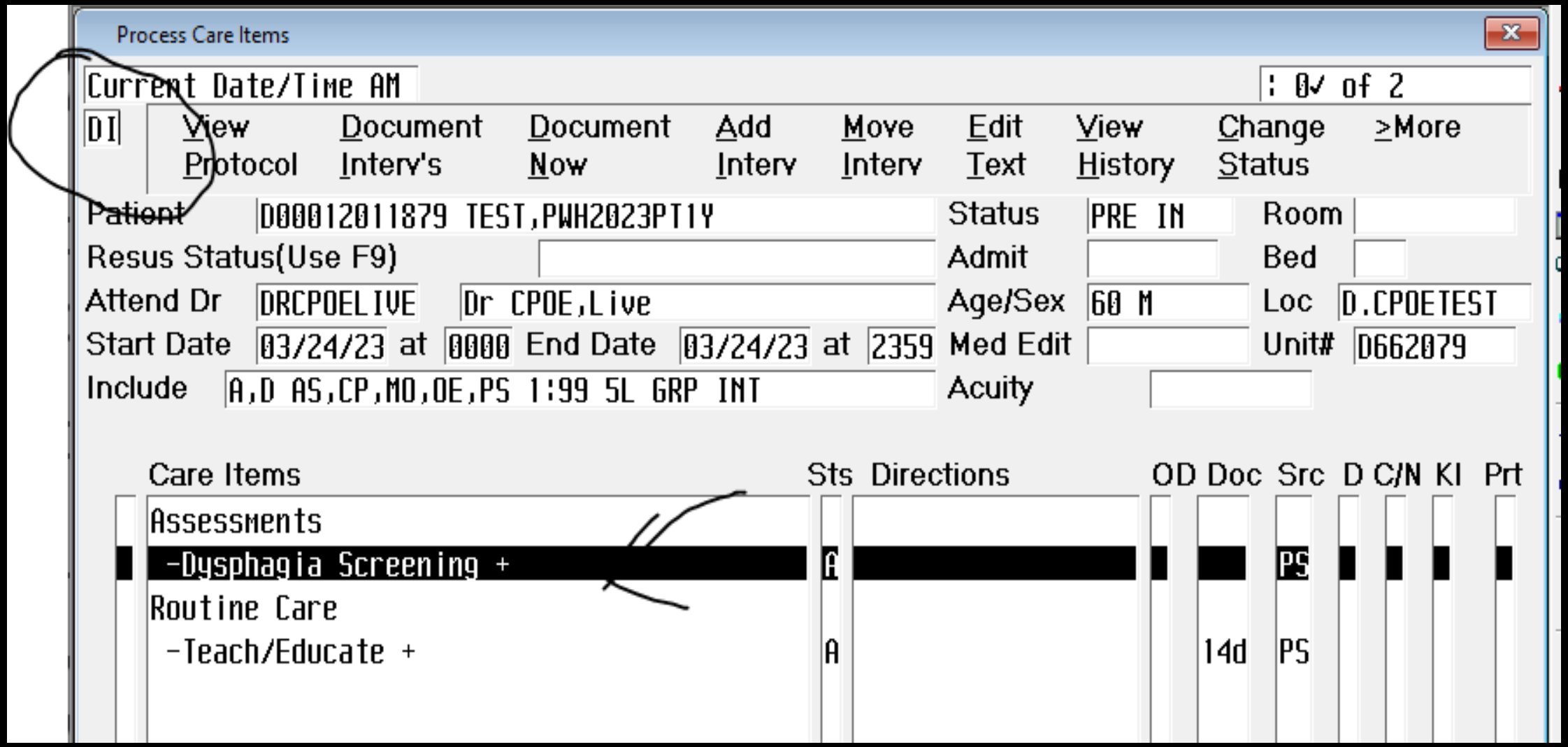


This is the correct Neuro check to document. Underneath where it says document stroke scale you have 2 choices. Choice 1 must be done once a shift and choice 2 can be used for all subsequent neuro checks.

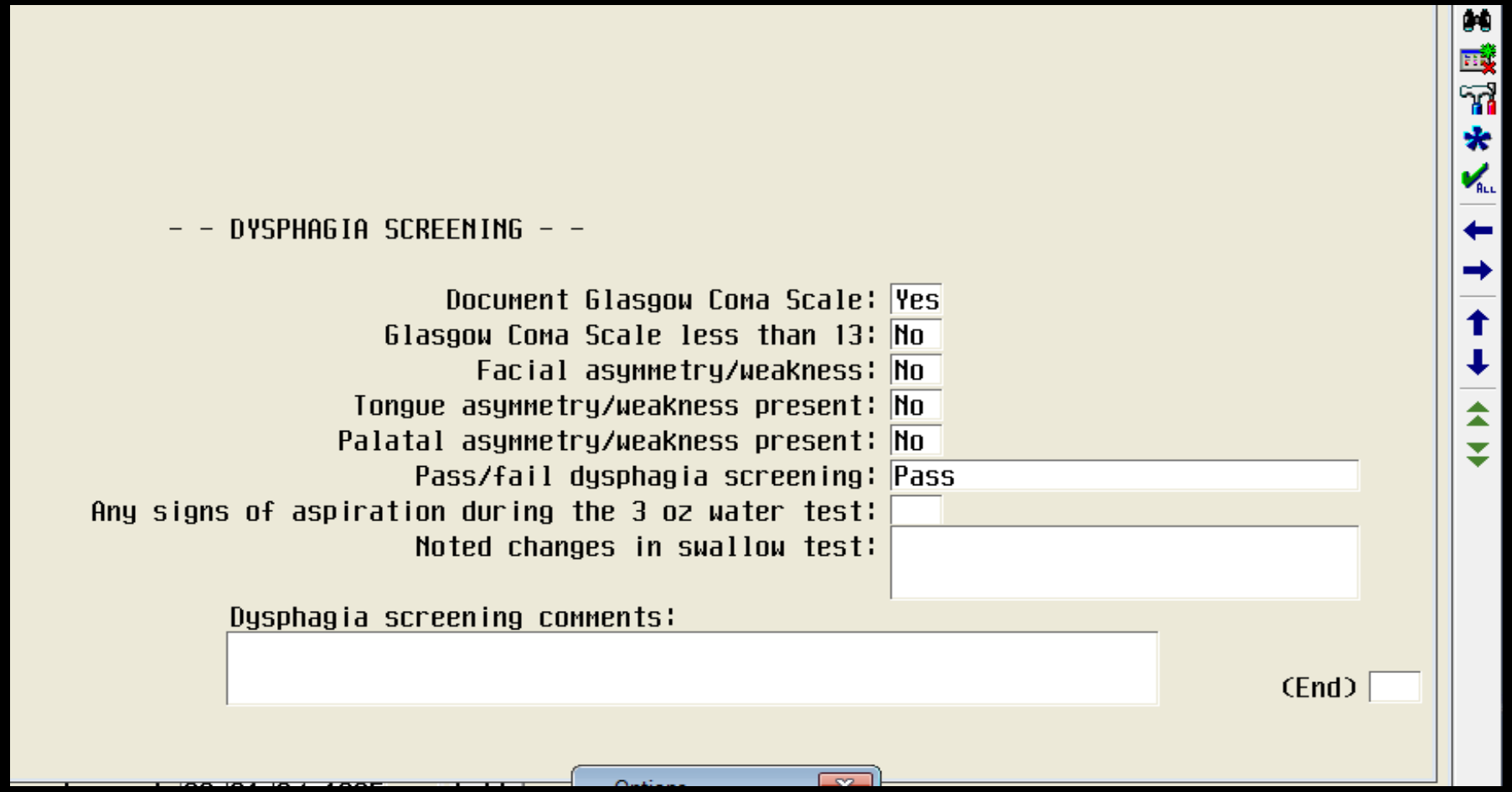
FREQUENT NEURO CHECKS

- ER is Q 15 min during a stroke alert. If no TPA then they are Q 1 hr until the patient is admitted including vital signs.
- ICU neuro checks and vital signs on all confirmed or rule out stroke patients is every hour unless otherwise ordered.
- Stepdown neuro checks and vital signs on all confirmed or rule out stroke patients is every 2 hours unless otherwise ordered.
- Tele/med-surg neuro checks and vital signs on all confirmed or rule out stroke patients is every 4 hours unless otherwise ordered.
- ER hold patients must be documented according to the unit they are admitted to there are NO exceptions.

DYSPHAGIA SCREEN UNDER PROCESS INTERVENTION- ADD INTERVENTION THEN DOCUMENT INTERVENTION

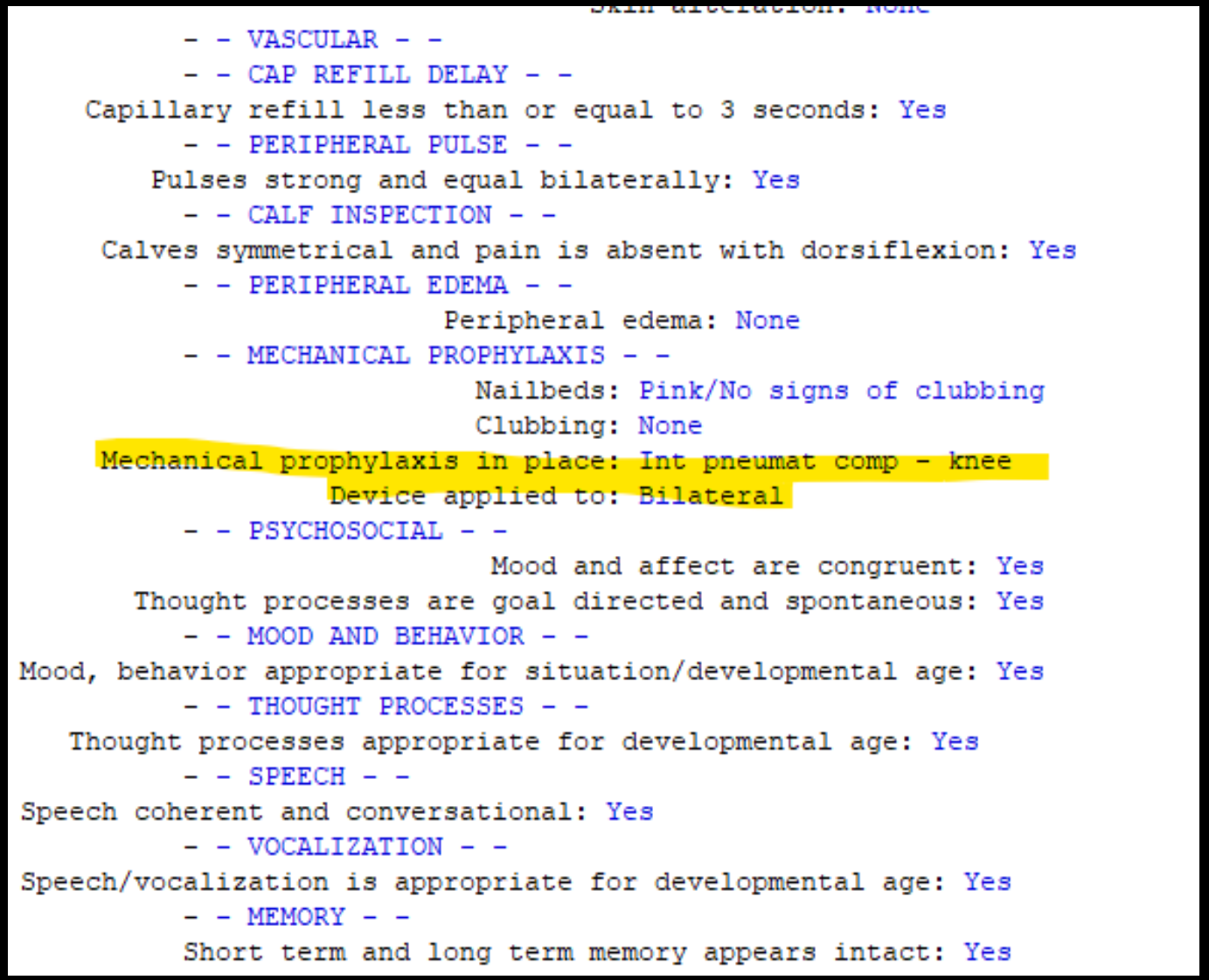


IF THEY FAIL THE DYSPHAGIA GIVE THEM RECTAL ASPIRIN



VTE PROPHYLAXIS

- SCD's, Lovenox 40 mg, and heparin subQ are the only acceptable documentation for VTE.
- It must be documented by the end of day 2 from arrival to the hospital not arrival to the floor.
- It is part of the admission/shift assessment documentation.



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- - VASCULAR - -
- - CAP REFILL DELAY - -
Capillary refill less than or equal to 3 seconds: Yes
- - PERIPHERAL PULSE - -
Pulses strong and equal bilaterally: Yes
- - CALF INSPECTION - -
Calves symmetrical and pain is absent with dorsiflexion: Yes
- - PERIPHERAL EDEMA - -
Peripheral edema: None
- - MECHANICAL PROPHYLAXIS - -
Nailbeds: Pink/No signs of clubbing
Clubbing: None
Mechanical prophylaxis in place: Int pneumat comp - knee
Device applied to: Bilateral
- - PSYCHOSOCIAL - -
Mood and affect are congruent: Yes
Thought processes are goal directed and spontaneous: Yes
- - MOOD AND BEHAVIOR - -
Mood, behavior appropriate for situation/developmental age: Yes
- - THOUGHT PROCESSES - -
Thought processes appropriate for developmental age: Yes
- - SPEECH - -
Speech coherent and conversational: Yes
- - VOCALIZATION - -
Speech/vocalization is appropriate for developmental age: Yes
- - MEMORY - -
Short term and long term memory appears intact: Yes
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ANTITHROMBOTIC BY DAY 2

- ASA or Plavix or both must be administered prior to the end of day 2 from arrival to the hospital on all confirmed or R/O stroke patients.
- Documenting NPO does not count and is not appropriate as the patient should be given rectal ASA in such a case.
- For example if the patient arrives to the ER at 23:59 this still considered day 1 and you now have less than 24 hrs to administer the ASA.
- If the patient received ASA at another facility it does not count for our core measures.
- If the provider chooses not to give the ASA they are responsible for documenting the reason why.

CORONARY RISK PROFILE

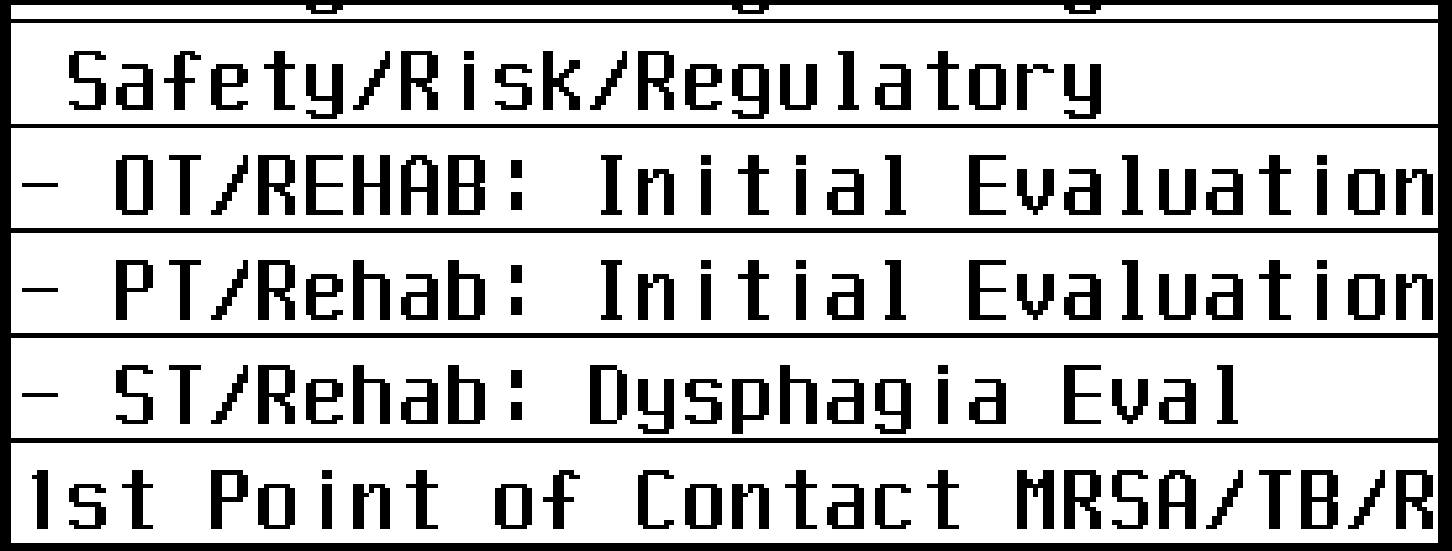
- This is required for ALL stroke patients.
- Any result greater > 70 requires a statin medication to be addressed

Procedure (Category)
PHOSPHATE (PHOSPHORUS) (LAB)
GLYCOHEMOGLOBIN A1C (LAB)
TSH w Reflex FT4 (LAB)
CORONARY RISK PROFILE (LAB)
TROPONIN I (LAB)
CORONARY RISK PROFILE (LAB)
CBC WITH DIFFERENTIAL (LAB)

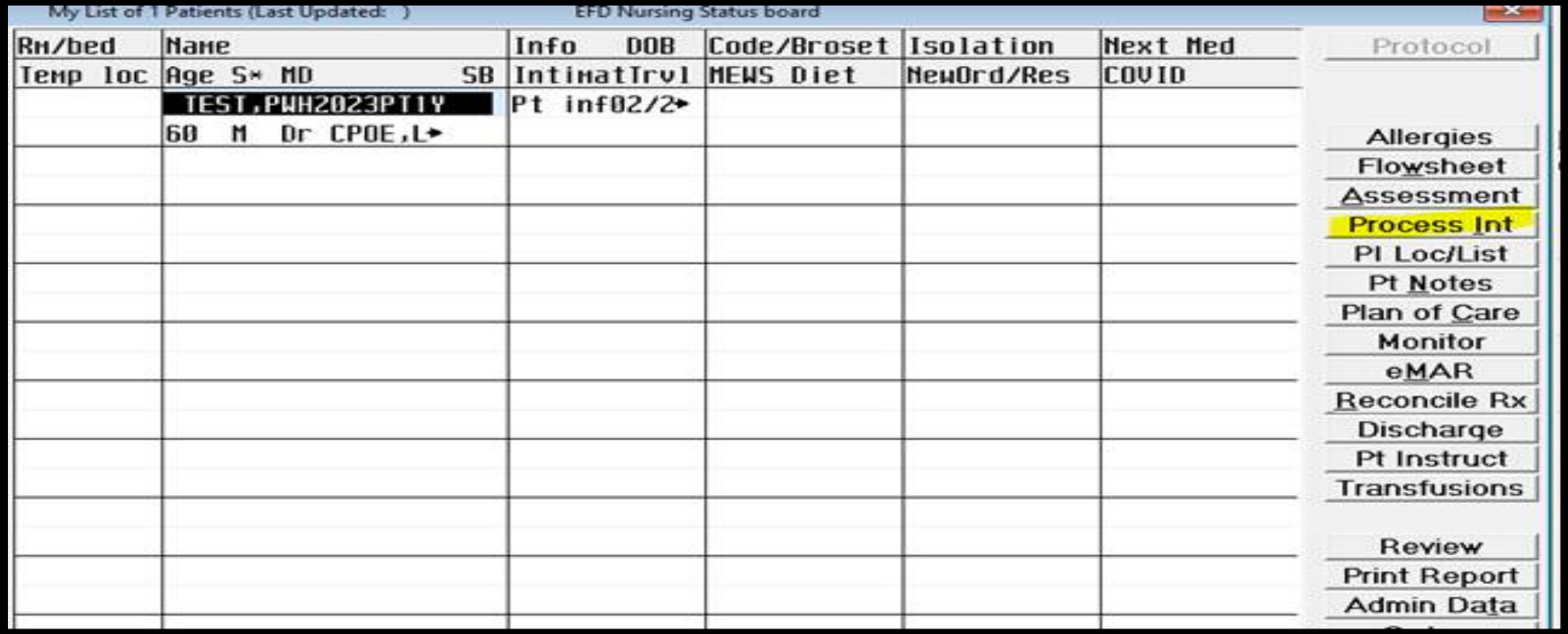
Test	Result
Troponin I	< 0.012
Total Protein	7.4
Albumin	4.2
Triglycerides	119
Cholesterol	214 H
LDL Cholesterol	137 H
Non-HDL (LDL + VLDL)	161
HDL Cholesterol	53
Heart Disease Risk Ratio	4.0
TSH	1.230

ASSESS FOR REHAB

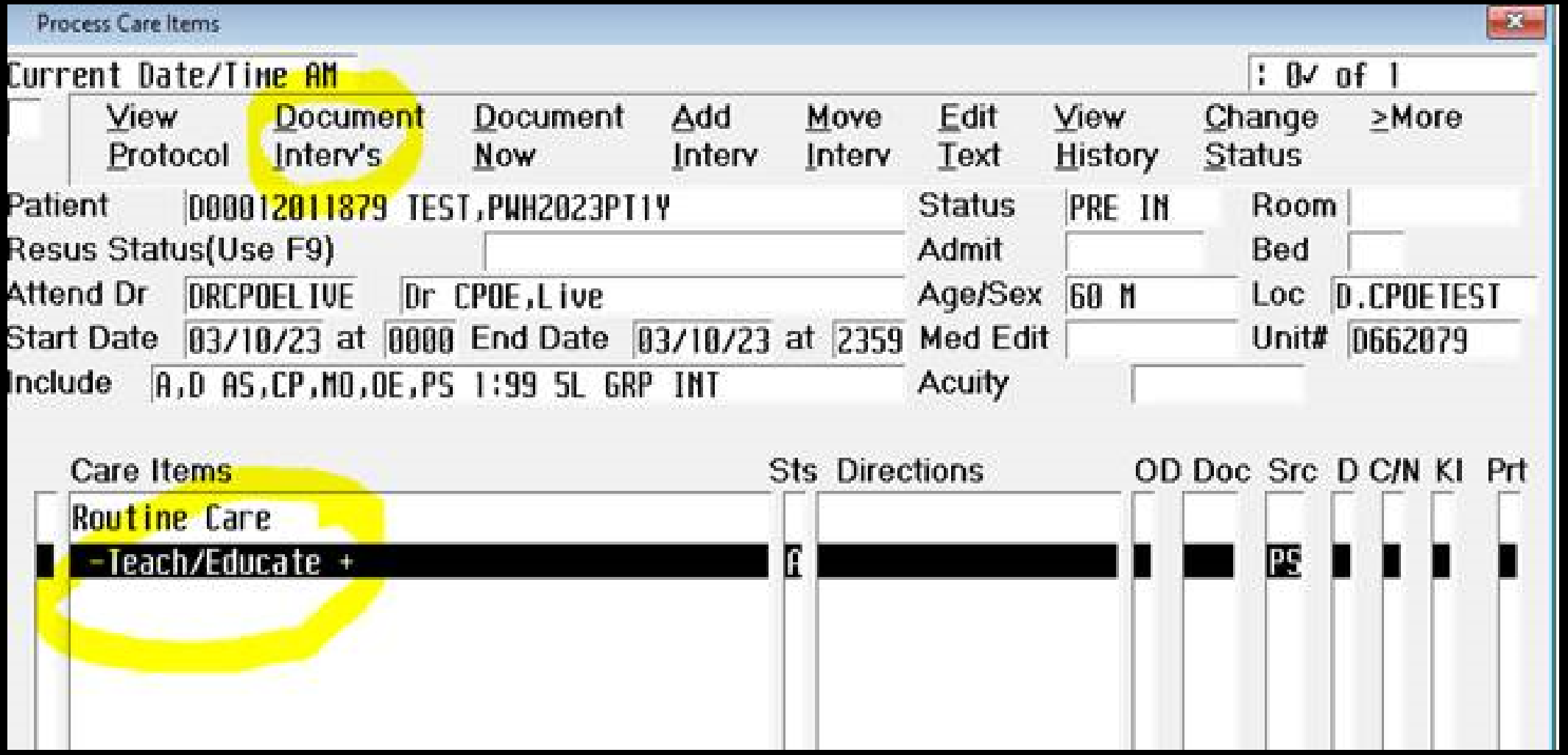
- Every Stroke and TIA patient must have an evaluation and treatment with PT/OT.
- Speech therapy is required on all acute stroke patients and those that fail the dysphagia screen.
- Being intubated or unresponsive is not an exclusion to this measure. The therapists know to document that they attempted to evaluate the patient for rehab but due to the patient's condition they were unable to. You can not refuse them seeing the patient.



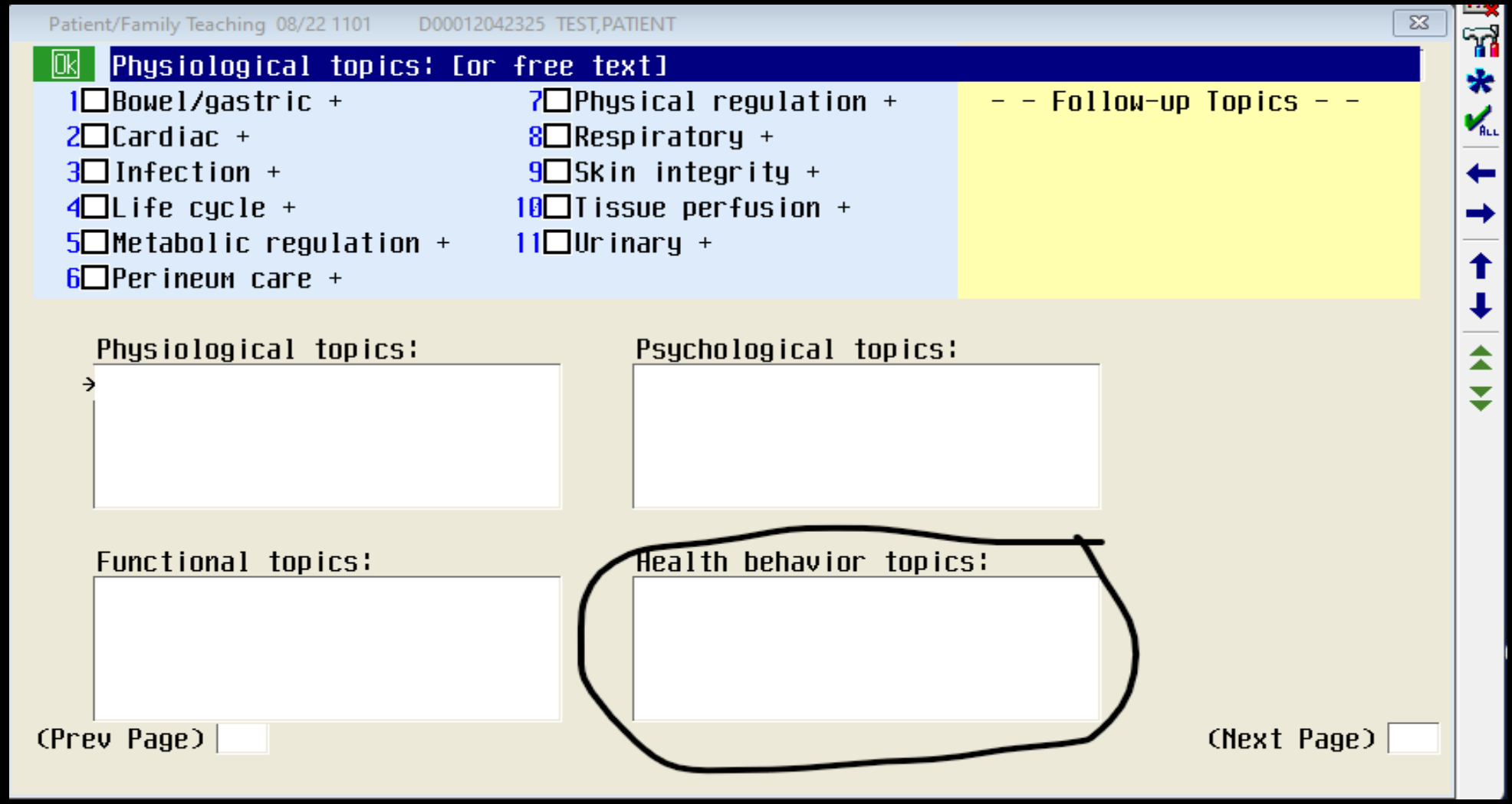
Documenting stroke education,
Step one: go under process intervention and find the teach/educate intervention



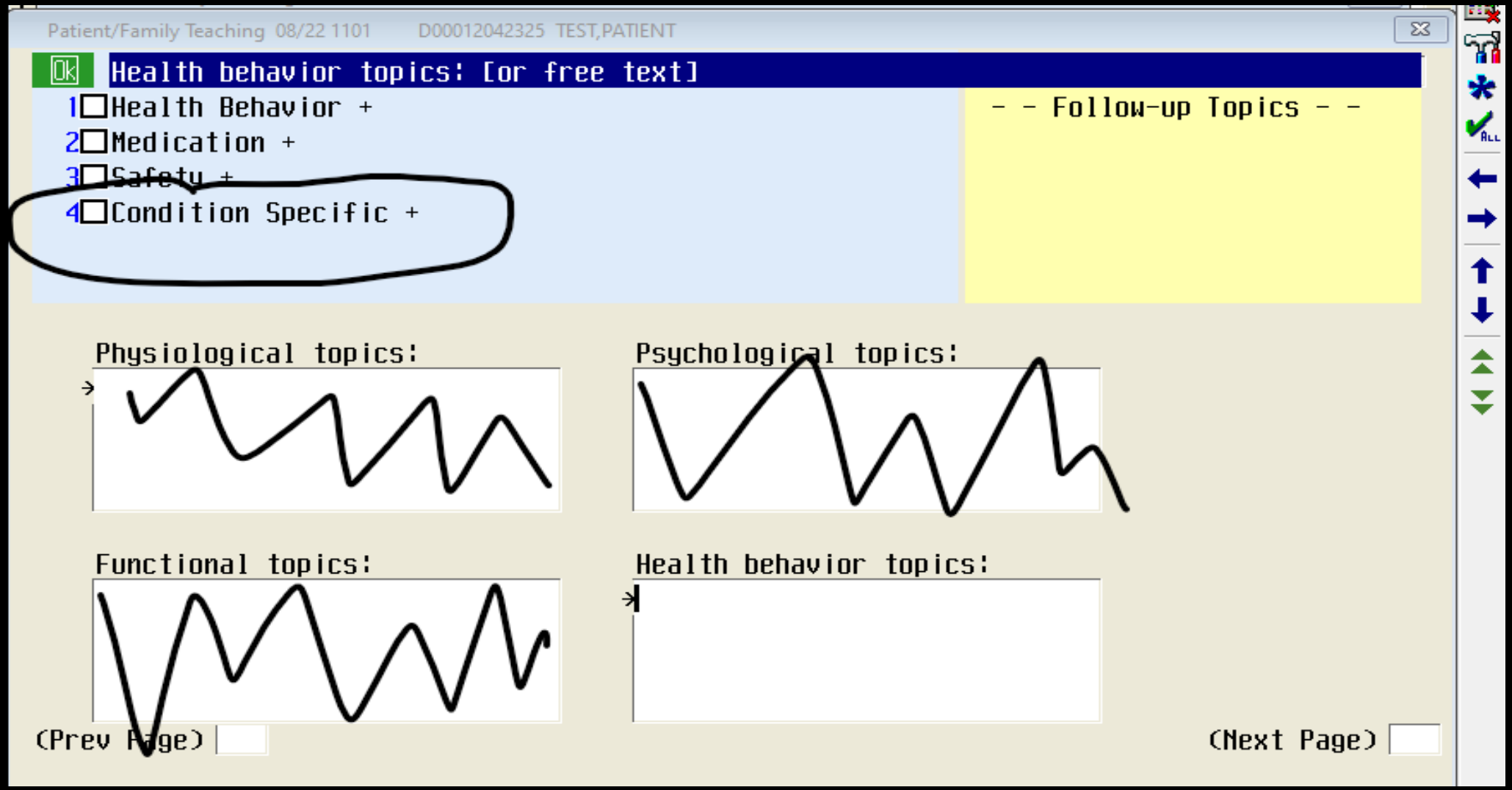
Step two: after selecting the teach/educate intervention go under document the intervention.



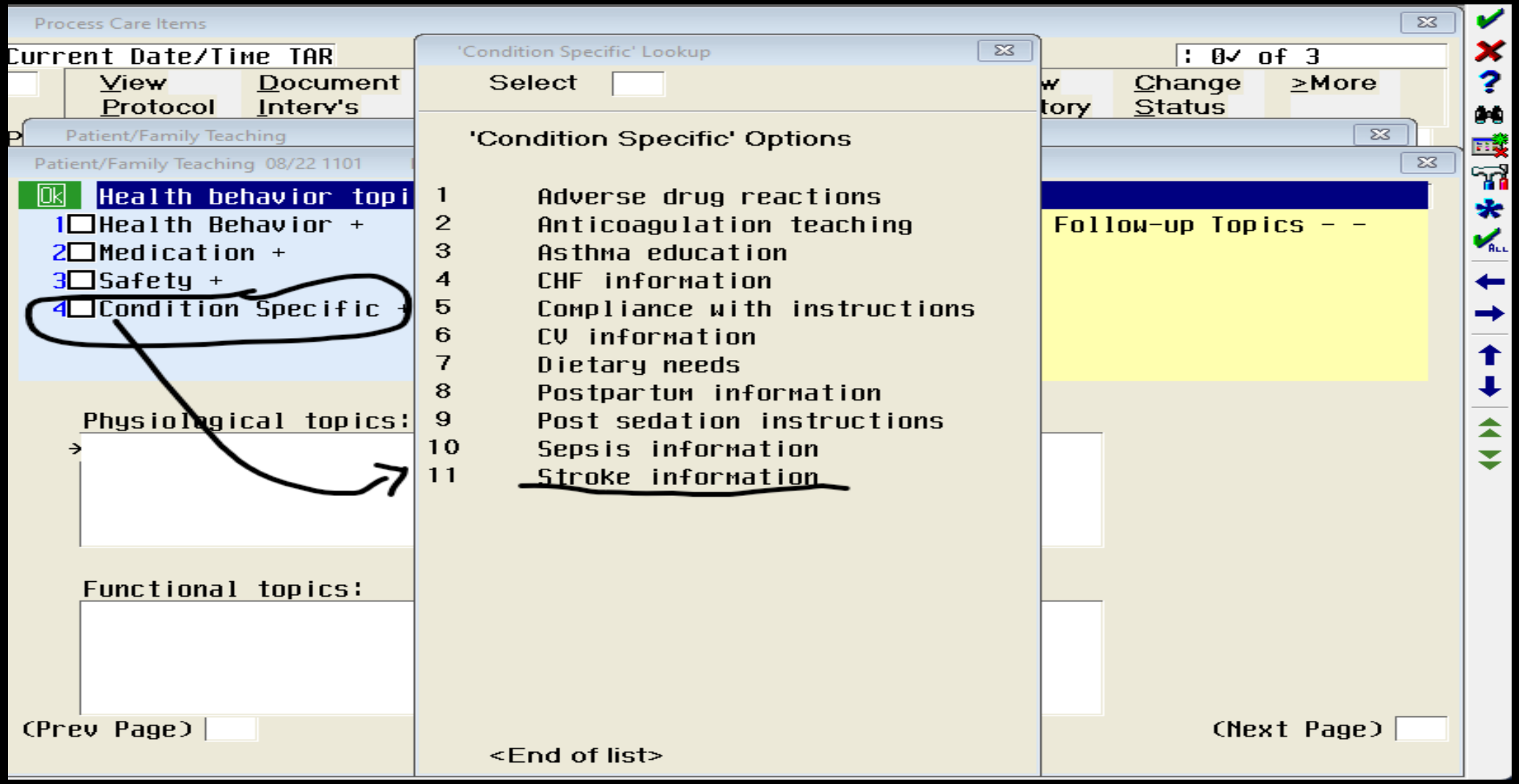
Step three: When you get to the topics that you can document under, select health behavior topics.



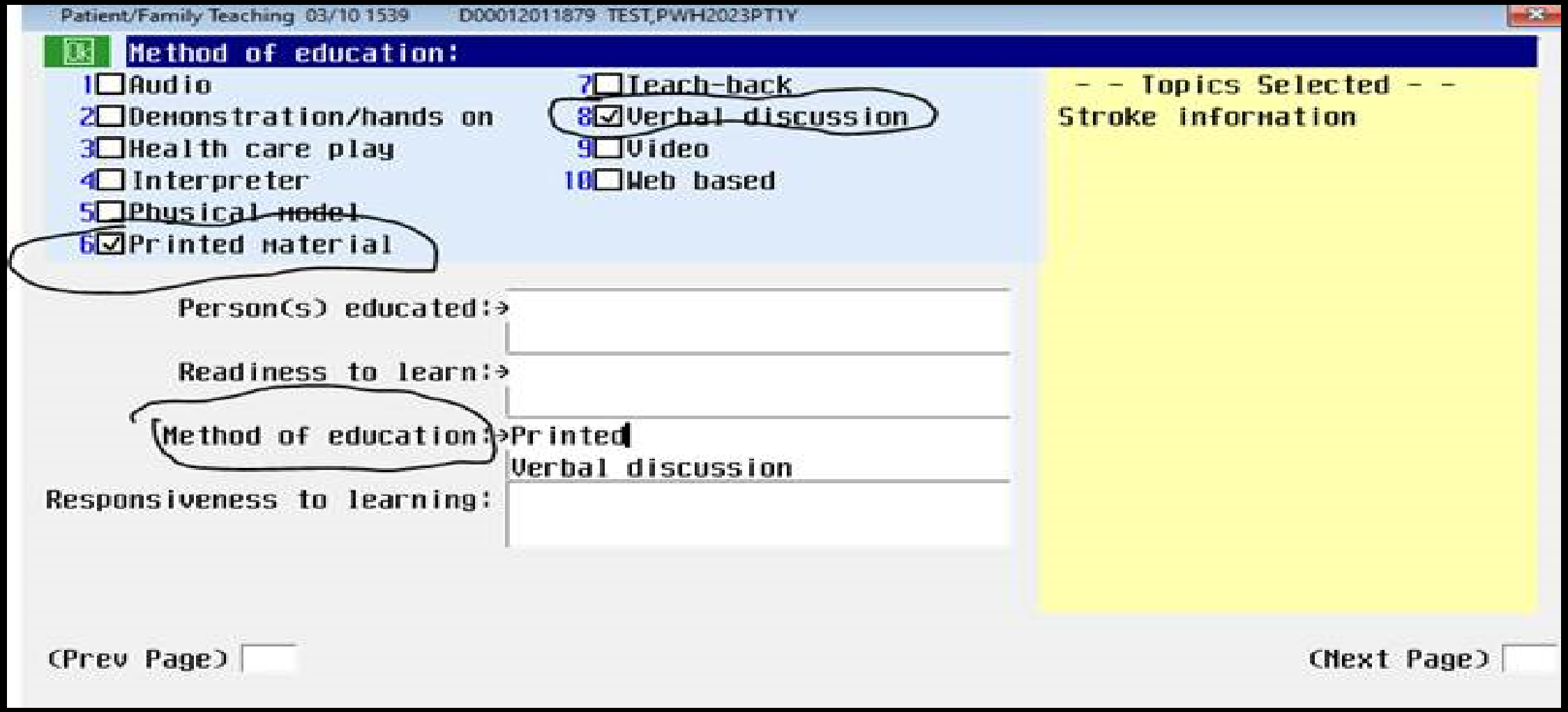
Step four: under health behavior topics select condition specific.



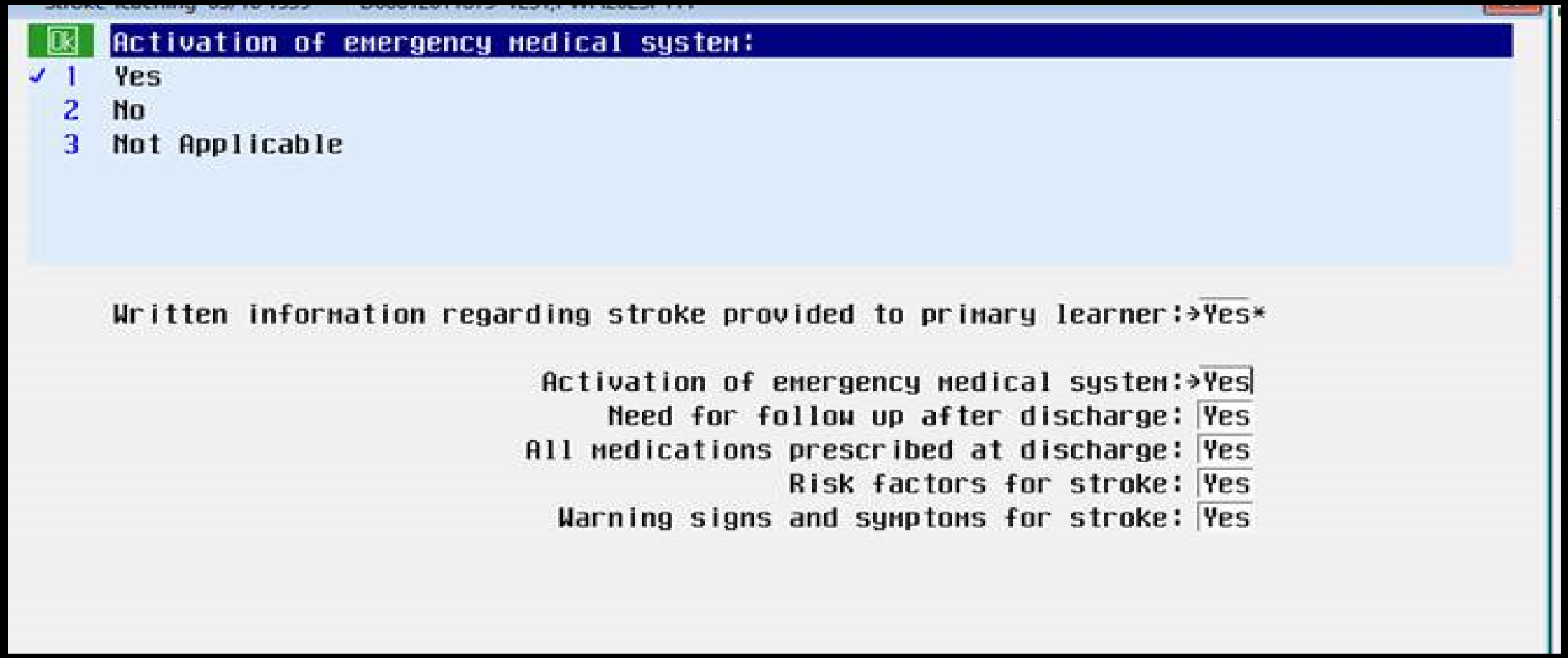
Step five: When you condition specific a new box will populate and then select #11 stroke information.



Step six: You must document #6 and #8 for methods of education.



If you did everything exactly as instructed, this screen will show up and just hit YES in the top box and then enter.



ASA AND STATIN FOR DISCHARGE

- Antiplatelet therapy in the form of ASA Plavix or other is required on ALL ischemic stroke patients. It MUST be on the final med reconciliation print out.
  - If provider chooses not to prescribe they must document why
- Statin therapy is required for ALL ischemic stroke patients and must be on the final med rec

- The final med reconciliation must be printed out and sent to medical records.

Anticoagulation is different and must be addressed on any patient that has hx of A-Fib or is currently in A-Fib.

STROKE REQUIREMENTS

- All ischemic stroke patients must be discharged with
  - An antiplatelet (ASA, PLAVIX, Effient, Brilinta, etc)
    - Or documentation must be present for exclusion
  - Anticoagulant only if atrial fibrillation in their medical history or was present at any point
    - Xarelto, Pradaxa, Eliquis, etc. OR THEY MUST DOCUMENT THE EXCLUSION
  - High intensity statin (even if they were already on a statin/lipid lowering medication it must be changed)

High-Intensity Statin Therapy	Moderate-Intensity Statin Therapy	Low-Intensity Statin Therapy
Daily dose lowers LDL on average by ≥50%	Daily dose lowers LDL on average by approximately 30-49%	Daily dose lowers LDL on average by <30%
Atorvastatin 40-80 mg Rosuvastatin 20-40 mg	Atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg BID Pitavastatin 2-4 mg	Simvastatin 10 mg Pravastatin 10-20 mg Lovastatin 20 mg Fluvastatin 20-40 mg

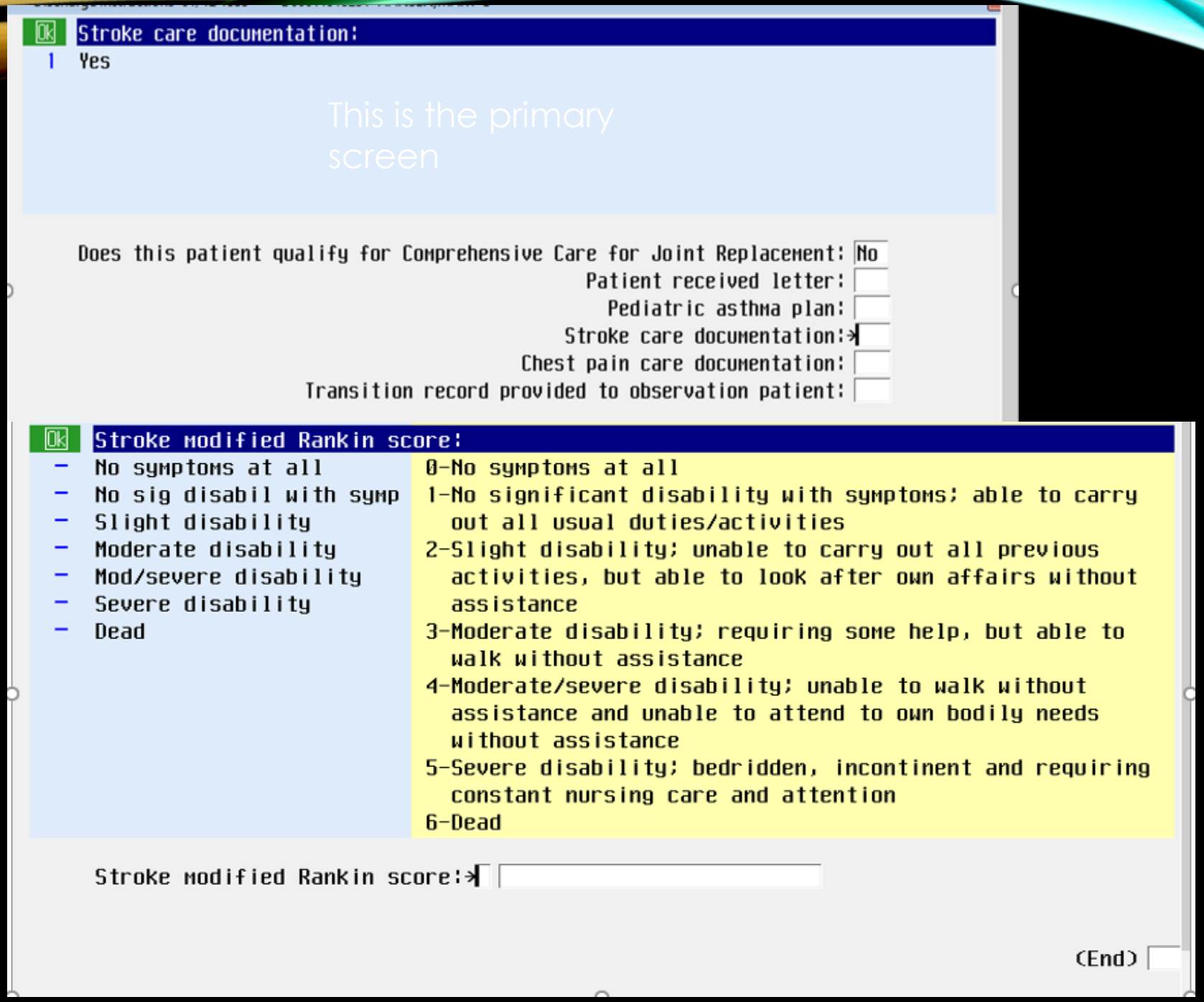
MODIFIED RANKIN SCALE

The mRS scale auto populates from the discharge assessment you perform.

Everyone seems to document the comprehensive joint replacement…its 3 boxes below it. Just select Y and then the mRS will automatically open up

It is how you get the modified Rankin Scale. If it speeds right past this do not hit f12 and go back through the screen until it stops on this

When you enter Y in the box it will populate the next screen which is required documentation

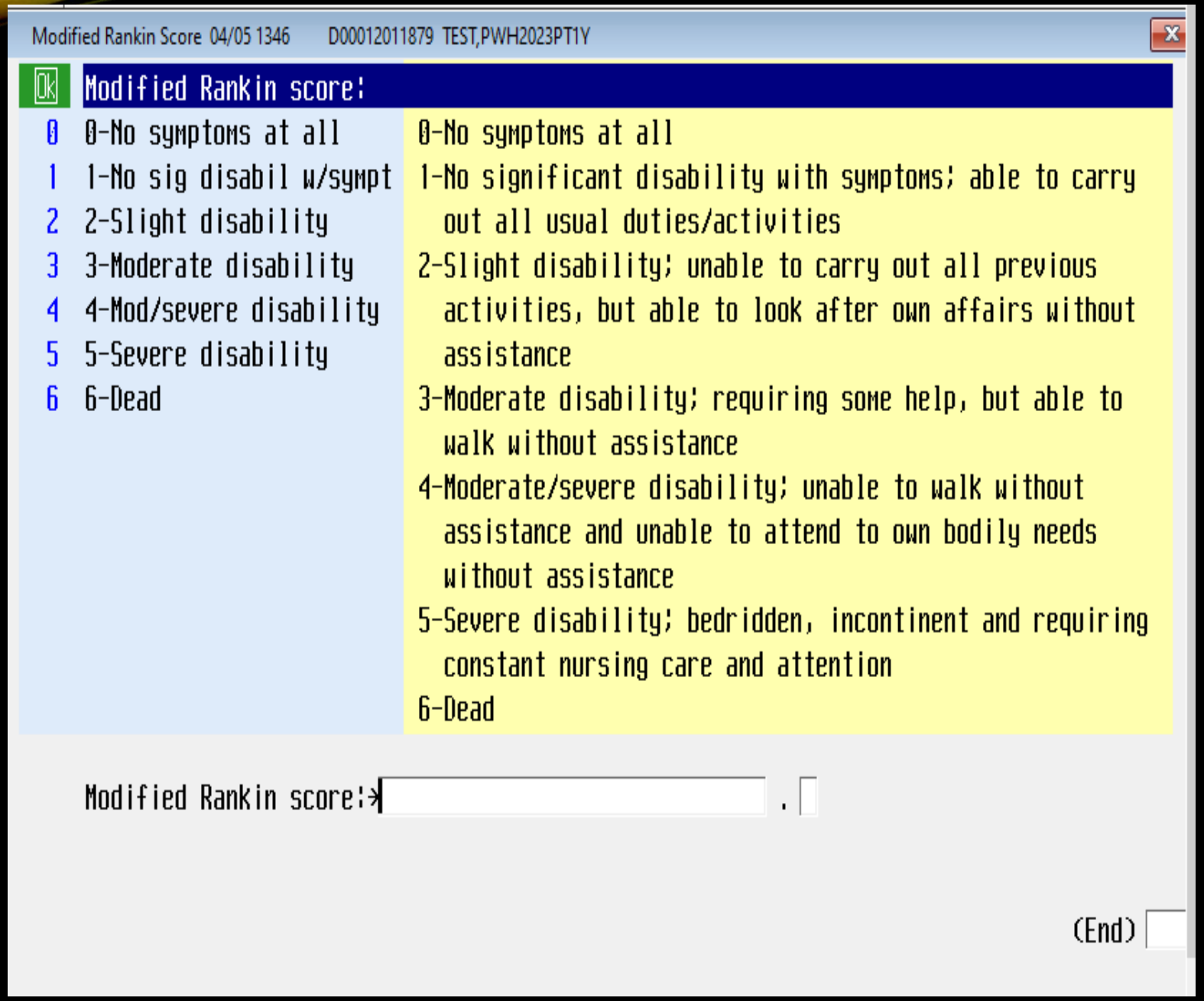


Modified Rankin Scale, this is what the individual intervention looks like. WE have usually added it for you.

This is a score given to the patient by the nurses of what they perceive the patient's disability to be.

It can be added as it's own intervention under the process intervention tab but ONLY COUNTS ON THE DAY OF DISCHARGE ☺

Refer back to the original slides to find how to add this



FINAL THOUGHTS

- Documenting “neurological system care” for teaching does not count for stroke
- Documenting NPO does not count as a dysphagia screen
- Neuro checks are Q1 hours for the ICU (ER is case dependent but should be every hour at a minimum), PCU is Q2 hrs, and tele/med-surg is Q4 unless otherwise ordered. The orders can be downgraded, but an upgrade should be moved to a higher level of care
- NIH must be documented every shift and with any neurological change
- There are stroke education folders on every unit in English, Spanish and Creole. If the documentation did not occur in MediTech this is a back-up to ensure compliance. Patient and nurse sign the form and it remains with the chart
- The modified rankin scale is required. It is part of the discharge instructions