



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 $0.25\text{mg} \times \text{pts weight in kilograms}$ -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

Assessments	PS	PS	PS	PS	PS	PS	PS	PS	PS
-Neurovascular Checks +	A								
-Frequent Neuro Checks +	A								
Routine Care									
-Tele App/Discon *Order Required* +	A								
-Teach/Educate +	A								
Physician Orders									
- MRSA Non ICU Decolonization	A								

Frequent Neuro Checks 08/22 1200 D00012042325 TEST,PATIENT

Document stroke scale:

- 1 NIH
- 2 Modified NIH

Level of consciousness:→

Document Glasgow coma scale: ☐

Document stroke scale:→

Document dysphagia screening: ☐

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

Process Care Items

Current Date/Time AM : 00 of 2

DI View Document Document Add Move Edit View Change >More
Protocol Interv's Now Interv Interv Text History Status

Patient 000012011879 TEST,PWH2023PT1Y Status PRE IN Room
Resus Status(Use F9) Admit Bed
Attend Dr DRCP0ELIVE Dr CPOE,Live Age/Sex 60 M Loc D.CPOETEST
Start Date 03/24/23 at 0000 End Date 03/24/23 at 2359 Med Edit Unit# 0662079
Include A,D AS,CP,MO,OE,PS 1:99 5L GRP INT Acuity

Care Items	Sts	Directions	OD	Doc	Src	D	C/N	KI	Prt
Assessments									
-Dysphagia Screening +	A				PS				
Routine Care									
-Teach/Educate +	A			14d	PS				

IF THEY FAIL THE DYSPHAGIA GIVE THEM RECTAL ASPIRIN


- - DYSPHAGIA SCREENING - -

Document Glasgow Coma Scale:	<input type="text" value="Yes"/>
Glasgow Coma Scale less than 13:	<input type="text" value="No"/>
Facial asymmetry/weakness:	<input type="text" value="No"/>
Tongue asymmetry/weakness present:	<input type="text" value="No"/>
Palatal asymmetry/weakness present:	<input type="text" value="No"/>
Pass/fail dysphagia screening:	<input type="text" value="Pass"/>
Any signs of aspiration during the 3 oz water test:	<input type="text"/>
Noted changes in swallow test:	<input type="text"/>

Dysphagia screening comments:

(End)

Options



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.

SKIN ulceration: None

- - 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

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.

Safety/Risk/Regulatory
– OT/REHAB: Initial Evaluation
– PT/Rehab: Initial Evaluation
– ST/Rehab: Dysphagia Eval
1st Point of Contact MRSA/TB/R

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

My List of Patients (Last Updated:)						EFD Nursing Status board	
Rm/bed	Name	Info	DOB	Code/Broset	Isolation	Next Med	Protocol
Temp loc	Age S* MD	SB	IntinatTrvl	MEWS Diet	NewOrd/Res	COVID	
	TEST, PWH2023PT1Y	Pt inf02/2▶					
	60 M Dr CP0E, L▶						
							Allergies
							Flowsheet
							Assessment
							Process Int
							PI Loc/List
							Pt Notes
							Plan of Care
							Monitor
							eMAR
							Reconcile Rx
							Discharge
							Pt Instruct
							Transfusions
							Review
							Print Report
							Admin Data

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

Process Care Items

Current Date/Time AM : 04 of 1

View Protocol	Document Interv's	Document Now	Add Interv	Move Interv	Edit Text	View History	Change Status	>More
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Patient 000012011879 TEST, PWH2023PT1Y Status PRE IN Room
Resus Status(Use F9) Admit Bed
Attend Dr DRCP0ELIVE Dr CP0E, Live Age/Sex 60 M Loc D.CP0ETEST
Start Date 03/10/23 at 0000 End Date 03/10/23 at 2359 Med Edit Unit# 0662079
Include A,D AS,CP,MO,OE,PS 1:99 5L GRP INT Acuity

Care Items	Sts	Directions	OD	Doc	Src	D	C/N	KI	Prt
Routine Care									
-Teach/Educate +	A				PS				

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

Patient/Family Teaching 08/22 1101 D00012042325 TEST,PATIENT

☐ Physiological topics: [or free text]

1 <input type="checkbox"/> Bowel/gastric +	7 <input type="checkbox"/> Physical regulation +	- - Follow-up Topics - -
2 <input type="checkbox"/> Cardiac +	8 <input type="checkbox"/> Respiratory +	
3 <input type="checkbox"/> Infection +	9 <input type="checkbox"/> Skin integrity +	
4 <input type="checkbox"/> Life cycle +	10 <input type="checkbox"/> Tissue perfusion +	
5 <input type="checkbox"/> Metabolic regulation +	11 <input type="checkbox"/> Urinary +	
6 <input type="checkbox"/> Perineum care +		

Physiological topics:

Psychological topics:

Functional topics:

Health behavior topics:

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Step four: under health behavior topics
select condition specific.

Patient/Family Teaching 08/22 1101 D00012042325 TEST,PATIENT

☒ Health behavior topics: [or free text]

1 ☐ Health Behavior +

2 ☐ Medication +

3 ☐ Safety +

4 ☐ Condition Specific +

-- Follow-up Topics --

Physiological topics:

Psychological topics:

Functional topics:

Health behavior topics:

(Prev Page)

(Next Page)

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

Process Care Items

Current Date/Time TAR

View Protocol Document Interv's

Patient/Family Teaching

Patient/Family Teaching 08/22 1101

☒ Health behavior topics

- 1 ☐ Health Behavior +
- 2 ☐ Medication +
- 3 ☐ Safety +
- 4 ☐ Condition Specific +

Physiological topics:

Functional topics:

(Prev Page)

'Condition Specific' Lookup

Select

'Condition Specific' Options

- 1 Adverse drug reactions
- 2 Anticoagulation teaching
- 3 Asthma education
- 4 CHF information
- 5 Compliance with instructions
- 6 CV information
- 7 Dietary needs
- 8 Postpartum information
- 9 Post sedation instructions
- 10 Sepsis information
- 11 Stroke information

<End of list>

Follow-up Topics - -

(Next Page)

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

Patient/Family Teaching 03/10 1539 D00012011879 TEST,PWH2023PT1Y

Method of education:

1 <input type="checkbox"/> Audio	7 <input type="checkbox"/> Teach-back
2 <input type="checkbox"/> Demonstration/hands on	8 <input checked="" type="checkbox"/> Verbal discussion
3 <input type="checkbox"/> Health care play	9 <input type="checkbox"/> Video
4 <input type="checkbox"/> Interpreter	10 <input type="checkbox"/> Web based
5 <input type="checkbox"/> Physical model	
6 <input checked="" type="checkbox"/> Printed material	

Person(s) educated:→

Readiness to learn:→

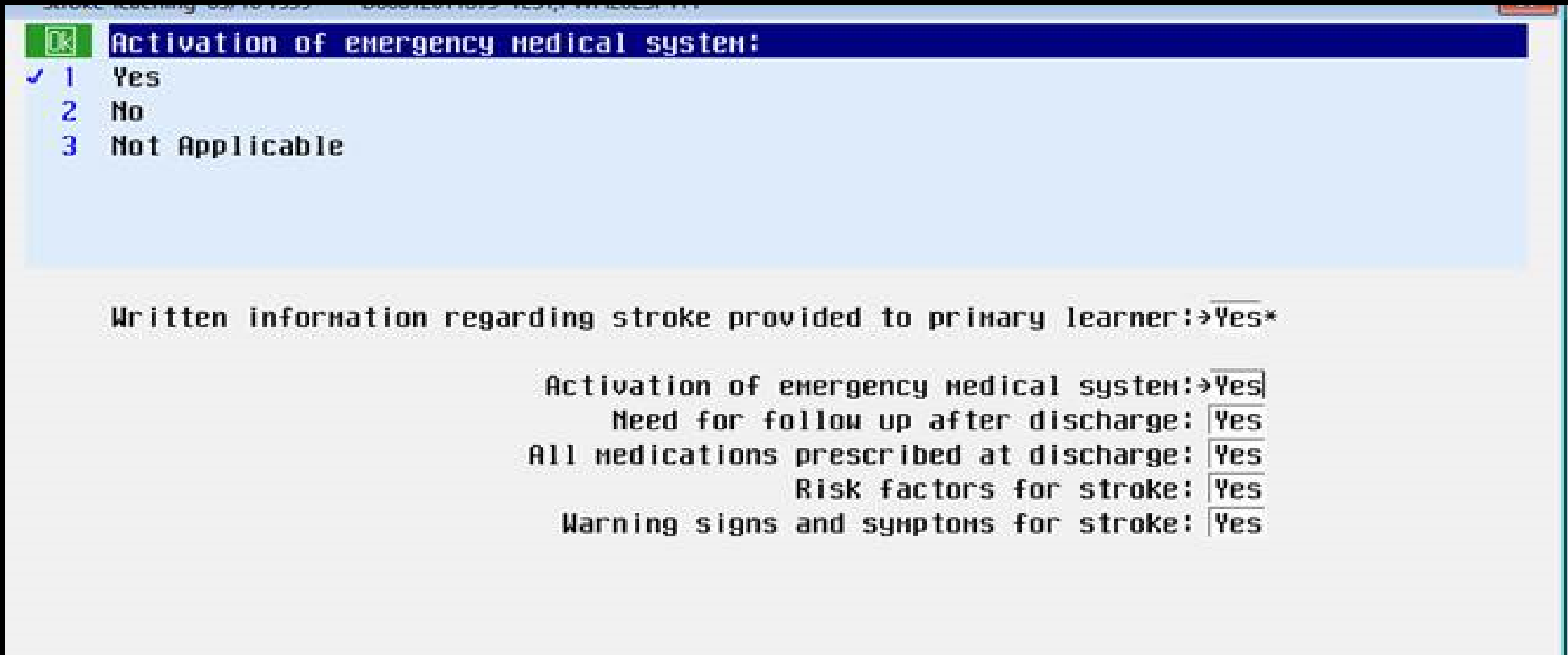
Method of education:→ Printed
Verbal discussion

Responsiveness to learning:→

-- Topics Selected --
Stroke information

(Prev Page) ☐ (Next Page) ☐

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



Stroke Learning

☒ Activation of emergency medical system:

- ✓ 1 Yes
- 2 No
- 3 Not Applicable

Written information regarding stroke provided to primary learner: → Yes*

Activation of emergency medical system: → Yes

Need for follow up after discharge: Yes

All medications prescribed at discharge: Yes

Risk factors for stroke: Yes

Warning signs and symptoms for stroke: Yes

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 $\geq 50\%$	Daily dose lowers LDL on average by approximately 30-49%	Daily dose lowers LDL on average by $\leq 30\%$
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

The screenshot displays two sequential screens from a medical software application. The top screen, titled 'Stroke care documentation:', features a blue header bar with an 'OK' button icon and the text 'Stroke care documentation:'. Below the header, there is a light blue area with the text 'This is the primary screen'. The main content area is white and contains a series of checkboxes for documentation: 'Does this patient qualify for Comprehensive Care for Joint Replacement?' (checked 'No'), 'Patient received letter:', 'Pediatric asthma plan:', 'Stroke care documentation:' (checked 'Y'), 'Chest pain care documentation:', and 'Transition record provided to observation patient:'. The bottom screen, titled 'Stroke modified Rankin score:', has a blue header bar with an 'OK' button icon and the text 'Stroke modified Rankin score:'. The main content area is white and displays a list of six options for the modified Rankin score, each with a corresponding description. The options are: 0-No symptoms at all, 1-No significant disability with symptoms; able to carry out all usual duties/activities, 2-Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance, 3-Moderate disability; requiring some help, but able to walk without assistance, 4-Moderate/severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance, 5-Severe disability; bedridden, incontinent and requiring constant nursing care and attention, and 6-Dead. At the bottom of the screen, there is a text input field labeled 'Stroke modified Rankin score:' and a button labeled '(End)'.

Stroke care documentation:

This is the primary screen

Does this patient qualify for Comprehensive Care for Joint Replacement: ☒ No

Patient received letter: ☐

Pediatric asthma plan: ☐

Stroke care documentation: ☒ Y

Chest pain care documentation: ☐

Transition record provided to observation patient: ☐

Stroke modified Rankin score:

- No symptoms at all
- No sig disabil with symp
- Slight disability
- Moderate disability
- Mod/severe disability
- Severe disability
- Dead

0-No symptoms at all

1-No significant disability with symptoms; able to carry out all usual duties/activities

2-Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3-Moderate disability; requiring some help, but able to walk without assistance

4-Moderate/severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5-Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6-Dead

Stroke modified Rankin score:

(End)

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

Modified Rankin Score 04/05 1346 D00012011879 TEST,PWH2023PT1Y

Ok

Modified Rankin score!

0	0-No symptoms at all	0-No symptoms at all
1	1-No sig disabil w/sympt	1-No significant disability with symptoms; able to carry out all usual duties/activities
2	2-Slight disability	2-Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3	3-Moderate disability	3-Moderate disability; requiring some help, but able to walk without assistance
4	4-Mod/severe disability	4-Moderate/severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5	5-Severe disability	5-Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6	6-Dead	6-Dead

Modified Rankin score:➤ .

(End)

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