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| |  |  |  | | --- | --- | --- | | **Huron Perth Healthcare Alliance** | | | | **1. Clinical Policies and Procedures** | Original Issue Date: | January 16, 2017 | | **CODE STROKE Process** | Review/Effective Date: | March 28, 2018 | | **Approved By: VP People and Chief Quality Executive** | Next Review Date: | March 28, 2020 | |
| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
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| **Scope:**  This policy applies to all Registered Nurses (RNs) and Registered Practical Nurses (RPNs) who have received appropriate theoretical preparation to care for inpatients older than 14 years of age that may be experiencing the signs and symptoms of a stroke at the Huron Perth Healthcare Alliance (HPHA).  **Policy Statement:**  It is the expectation that all RNs and RPNs are having the theoretical knowledge required to identify possible stroke will activate this patient response immediately with the aim of preserving brain function. This policy describes the procedural steps required to initiate immediate care for an inpatient experiencing the signs and symptoms of a stroke.  **Purpose:**  - To ensure standardized and consistent response to adult inpatients experiencing stroke symptoms while in hospital.  - To define when CODE STROKE will be activated  - To outline the expectations of team members prior to and during a CODE STROKE  - To outline the site-specific steps required of all staff during a CODE STROKE  - To provide the site-specific limitations of CODE STROKE response  **Definitions:**  CODE STROKE: A process established within the HPHA setting to initiate rapid response to inpatients older than 14 years of age presenting with acute stroke symptoms. Code Stroke aims to guide HPHA staff in the initiation of appropriate and timely stroke care and treatment within the 4.5 hour window per Canadian Stroke Best Practice recommendations. This 4.5 hour window begins from the time where the patient was last seen normal (LSN).  Tissue plasminogen activator (tPA): An enzyme medication obtained from the pharmacy department (Omnicell) given intravenously to assist with the dissolution of arterial and vascular thrombi. . It is recommended that tPA be administered within the 4.5 hour window only in order to achieve optimal patient outcomes.  Stroke Care Pathway: A set of best practices that the HPHA has embedded into our care processes to ensure that patients experiencing stroke symptoms receive care that is patient centred, safe, timely, effective, equitable and efficient. The Stroke Care Pathway is based upon evidence based care which is supported by standards of care identified within the Provincial Quality Based Procedures Handbook.  **Indications:**  Any admitted inpatient older than 14 years of age with a sudden onset of one or more of the following:  - Unilateral facial drooping  - Unilateral arm or leg weakness  - Slurred or jumbled speech  **Considerations:**  - The time last seen normal MUST be within the 4.5 hour in order to initiate Code Stroke and prevent patient harm.  - The MRP must be notified  - The primary nurse shall be required to be present to appropriately assess the patient for stroke symptoms. If the primary nurse is on a break, he/she shall be required to return to the clinical unit immediately.  **Competency Requirements:**  RNs and RPNs - successful completion of the code stroke eLearning  Any RN or RPN having appropriate theoretical preparation and understanding of the FAST signs and symptoms (see number 1 below under initiating Code Stroke) and responding in an appropriate manner as per this procedure.  If RPN is primary nurse , there will be a consult with an RN to determine if transfer of care is necessary in accordance with the College of Nurses (CNO) three factor framework.  **Procedure:**   |  |  | | --- | --- | | **Procedure** | **Rationale** | | Equipment:  · tPA kit from ED or ICU  · Documentation folder (red folder) from ED or ICU | • Timely access to tPA  • Provides reference to process and documentation sheets |   Initiating Code Stroke – Stratford:  (\*see section at end of policy for Code Stroke response at Clinton, St. Marys and Seaforth sites)  The following steps shall be followed:  NOTE: If respiratory status is affected, a CODE BLUE must be activated  1. Identify if the patient has one or more of the following FAST symptoms:  Face: Is it drooping  Arms: Can they raise both arms?  Speech: Is it slurred or jumbled?  Time: When was the last seen normal time?  NOTE: If the primary bedside nurse is on break, they should be paged and return to the unit to assess patient.  2. Primary bedside nurse or nurse that is familiar with the patient immediately notifies the MRP and in consultation, activates the Code Stroke through switchboard by dialing ‘1111’ or pressing the ‘Hotline” button (If MRP does not respond in 5-10 min, primary nurse may use critical judgement and activate Code Stroke)    3. Nurse or unit clerk to page Internist between 8:00-20:00 with  (\*9) to indicate stroke    4. Switchboard operator initiates the CODE STROKE with an overhead page. Announce “Code Stroke, Building, Floor, Room Number” x2. Switchboard operator completes the Electronic Code Reporting Form on MyAlliance.  5. Nurse or unit clerk to print off most recent physician consult note, medications and bloodwork.  6. Nurse to begin documentation on Code Stroke record located in red Stroke folder and crash cart  The following people are members of the Code Stroke Response Team:  -  Internist –page Internist with  (\*9) to indicate stroke between 8:00-20:00  -  ED Physician –will attend after 5 pm Monday to Friday and anytime on weekends or when informed no Internist in house.  -  CT suite – to prepare for potential stroke protocol  -  Laboratory – to attend location to draw necessary lab work  -  Code Stroke nurse – (CCU Code Nurse – bring Stroke Protocol Red Folder and tPA- found under global list in Omnicell as patient “Code Stroke” )  -  Stroke Strategy Nurse  -  PSW or designate from ISU to bring code stroke stretcher   Code Stroke Team arrival and responsibilities:  -  Code Stroke Lead is the physician upon Code Stroke Team arrival   Code Stroke Nurse attends with necessary equipment; tPA and red Stroke folder  Upon arrival, the Code Stroke Team will verify that the last seen normal time is less than or equal to 4.5 hours.  Code Stroke Team will collaboratively determine if patient presentation is consistent with possible acute stroke and direct subsequent patient care.  **ED Physician:**  If it is determined that patient presentation is not consistent with possible acute stroke the ED Physician:  - will consult with MRP to ensure appropriate clinical follow up and treatment.  If it is determined that patient presentation is consistent with possible acute stroke the ED Physician:  - will page Internal Medicine, and initiate the Stroke Care Pathway ([V3 Final Hyper Acute Stroke Pathway](https://intranet.hpha.ca/myalliance/doc.aspx?id=6482))  **Primary Bedside Nurse shall initiate following:**  - Notify CT suite to clear the table for stroke protocol ([revised SGH ED Stroke Protocol Nov 132017](https://intranet.hpha.ca/myalliance/doc.aspx?id=6481))  -  Notify ED to bring weigh stretcher to CT suite   - Enter CT order immediately into Meditech clearly stating the symptoms of the stroke and indicate left or right sided weakness  - IF no family available for consent, send patient with a consent signed by the physician in the patient’s chart. Consent form located in red Stroke folder  - Place the patient on a cardiac monitor and initiate vital signs and neuro monitoring q15 min  - Ensure there is a patient weight documented in the chart.  - Ensure the patient has 2 IVs, one of which is an 18G in the antecubital for CT with the second IV reserved for tPA. This IV shall be an 18G or 20G and located in the patient’s forearm, not the antecubital fossa.  - Ensure that STAT ordered bloodwork has been drawn. Ensure that “Stroke Protocol” labels are placed inside the biohazard bag. Ensure that lab work has been sent and that the lab has been notified via a phone call.  - Prepare the patient for transport to CT suite. The Primary Nurse shall remain with the patient.  - Initiate the Telestroke process if directed by the physician (physician may be comfortable delivering tPA on their own but may wish to call Telestroke for complicated cases)  Code Stroke Nurse shall initiate the following:  - Obtain an order from the attending physician to administer tPA medication (ED nurse available as a resource if needed). Monitor for patient response.   NOTE: tPA may be administered in the CT suite, ICU or Integrated Stroke Unit upon the direction from Internal Medicine.  **NOTE:**  - The Alteplase (tPA) Administration Order Set shall be initiated by the Physician.   \* The patient will be held in the CT stretcher bay after they have had their Hyperacute CT Angiogram until next steps are determined. The Code Stroke team may initiate the tPA in the stretcher bay saving critical moments.  \*If Telestroke requested, then patient will be moved to ED.  - If the patient is a candidate for Neurointerventional Radiology, endovascular thrombectomy (EVT) arrangements will be made by the physician to transfer the patient to an appropriate facility. This includes notification through CritiCall.  - The care needs of the patient will be assessed to determine appropriate placement of patient.  - If the patient requires telemetry monitoring in addition to stroke care, care and treatment shall take place within the Acute Stroke Unit - E3-500.  - If the patient requires airway support or further ICU management, admission to E2-600 shall be facilitated.  \*On arrival of the Code Stroke Team, the needs of the patient and required supports will be determined.  Code Team nurses that are present for Code Stroke will determine the level and skill set of nursing support required. Those not required will return to their units.  \*Ensure Code Stroke Debrief form is completed  **Initiating Code Stroke – St Marys, Clinton and Seaforth – If a tPA candidate:**  1. Identify if the patient has one or more of the following FAST symptoms:  Face: Is it drooping?  Arms: Can they raise both arms?  Speech: Is it slurred or jumbled?  Time: When was the last seen normal time?  2. The primary bedside nurse obtains the last seen normal time. If the primary bedside nurse is on break, they should be paged and return to the unit.  3. Primary bedside nurse immediately notifies the MRP/ED physician.  **MRP/ED Physician:**  1. Identifies potential stroke as per the FAST signs and symptoms and last seen normal time.  2. Ensures that the patient’s care needs are assessed to determine the most appropriate treatment location.  3. Contacts CritiCall to arrange transfer to closest stroke centre  **Primary Bedside Nurse:**  Place the patient on a cardiac monitor and initiate vital signs and neuro monitoring q15 min  i. Ensure there is a patient weight documented in the chart.  ii. Ensure the patient has 2 IVs, one of which is an 18G in the antecubital for CT with the second IV, reserved for tPA. This IV shall be an 18G or 20G and located in the patient’s forearm, not the antecubital fossa.  iii. Ensure that STAT ordered bloodwork has been drawn. Ensure that “Stroke Protocol” labels are placed inside the biohazard bag. Ensure that lab work has been sent and that the lab has been notified via a phone call to fax results to receiving ED.  Prepare the patient for transport to stroke centre CT suite. The Primary Nurse shall remain with the patient  Follow the ED to ED Emergency Stroke Transfer algorithm ([ED to ED Emergency Stroke Transfer Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=6715))  **References:**  Clinical Handbook for Stroke (Acute and Post-Acute) <http://www.hqontario.ca/Evidence-to-Improve-Care/Recommendations-and-Reports/Clinical-Handbooks-for-Quality-Based-Procedures>  In-Hospital Code Stroke Protocol Victoria Hospital Wards, London Health Sciences Centre, Feb. 22, 2016. |