

Clinical Practice Manual - Policy: CPM700 - 2

Title: Acute Stroke & TIA: Care Guidelines

Policy Statement/Purpose:

The purpose of this care guideline is to provide the clinical staff with an outlined process for the management of patients presenting with symptoms of acute stroke, transient ischemic attack (TIA), or new neurological event. As a **Primary Stroke Service** hospital, we have developed guidelines in accordance with best practice models from the Department of Public Health, American Stroke Association, and the Get with the Guideline Program.

The ultimate judgment regarding the care of each patient is made by the provider, in light of all circumstances relevant specifically to that patient. These practice guidelines can be viewed as standards to be considered for each patient in an attempt to individualize treatment.

As a PSS Hospital our goal is to achieve and adhere to the DPH/ASA guidelines for “Timelines of Care”:

1. Door to CT/Scan start time of **≤ 25 minutes**
2. Door to Image Interpretation by treating MD **≤ 45 minutes** for any patient being transferred to another facility
3. Door to Needle Time **≤ 60 minutes** (45 minutes in near future)
4. If Last Known Well is **≤ 3.5 hours** administer tPA within 4.5 hours from arrival, for those patients who meet the tPA inclusion/exclusion criteria.
5. For all patients who arrive with a Last Known Well > than 4.5 hours, but < 6 hours, assess for Large Vessel Occlusion (LVO) with a CTA head/neck. If LVO present discuss with BIDMC Stroke Service whether patient is a possible endovascular clot retrieval candidate.
6. For those patients who receive tPA, they will not have a CTA, unless ordered by Neurology. Post tPA they will be emergently transferred to BIDMC or other tertiary center for post tPA care
7. For patients who arrive **≥ 6 to < 24 hours** from Last Known Well and with an NIHSS **≥ 6**, obtain CTA head/neck. If there is a LVO, discuss with BIDMC Stroke Service whether patient is a possible endovascular clot retrieval candidate.

Procedure for Implementation:

- A. Different algorithms and care guidelines have been established depending on the patient’s presentation and whether they arrive via the emergency department, are an inpatient, or are a patient in one of our Outpatient clinic settings.
(See attachments for complete guidelines: CPM 700-2a Acute Stroke Algorithm – ED, CPM 700-2b Inpatient Acute Neurological Event Algorithm), CPM 700-2j Acute Neurological Event Algorithm for all Outpatient Clinic Patients, or Visitors, and CPM 700-2k Acute Neurological Event Algorithm for all Surgical and PACU Patients)

1. "Acute Stroke Care Algorithm" (CPM 700-2a) – is followed for those patients who present to the Emergency Department with stroke symptoms.

These patients may or may not be eligible to receive TPA depending on their assessment by our ED MD and/or our Tele-Medicine Physicians.

If they receive TPA, **and are eligible for intravascular clot removal**, or are diagnosed with any form of **Hemorrhagic Stroke**, they will be transported into BIDMC via rapid transport after discussion with the covering BIDMC **Neurology Fellow/Interventionalist**.

- a. Acute Stroke documentation forms are kept on each inpatient care unit in Acute Neurological Event notebooks at the Nurses stations with all forms necessary.
- b. "Inpatient Acute Neurological Event Guideline" (CPM 700- 2b) is followed for those patients who are Inpatients at BID-Needham and develop neurologic deficits.

A rapid response team is initiated and the Inpatient Acute Neurological Event Algorithm is followed utilizing a Tele-Medicine consult.

If assessed as ICH, Acute Stroke tPA, or an acute Neurological Event (determined by the MD to need a higher level of care), these patients will be transferred to a Tertiary ICU Inpatient Unit via Rapid Transport to BIDMC after MD to MD discussion with the covering:

1. BIDMC Stroke Fellow (Portal page 3-7828)
2. Speak with the BIDMC Transfer Center **number is 617-754-2759,**
beeper # 92466

Post t-PA inpatients, should be transferred to our ICU, while transfer via Rapid Transport to BIDMC is arranged.

Should there be a delay in transfer or bed availability, our MD can call: #42450 - Main ED Number, speak with the ED Attending to try and arrange a transfer to the ED at Beth Israel Deaconess Boston.

If there is a still a delay in arranging an emergent transfer, the Hospitalist may call the Beth Israel Deaconess – Needham ED Attending for help with facilitating a transfer.

- c. For Outpatient Clinic patients: A Rapid Response will be called by the clinic staff, the responding Hospitalist will evaluate the patient and determine if: the patient should be sent directly to the Emergency Department for continued care. The Hospitalist will call and coordinate patient care with the Emergency Department MD.
- * There must be Physician to Physician hand off reporting from the treating Physician to the accepting ED Physician either prior to, or at the time of transfer to the ED.
- d. The "Inpatient Acute Neurological Event Guideline" (CPM 700-2b) is to be followed and a Tele-Medicine consult is to be utilized for any patient who develops new Acute Neurological Signs and Symptoms or Deficits relating to trauma, questionable cord injury, seizures, or any other acute neurological changes.
- e. If determined that no Acute Event has occurred, a consult with the on-call Neurologist at BID-Needham will be requested.
- f. All patients admitted to a Medical Unit will have a Nursing Swallow Assessment completed prior to receiving anything by mouth, including medications.
- g. "Inpatient Stroke Rehabilitation Guidelines" – maps out the overall process by which the rehabilitation needs of the stroke patient are identified, addressed, and discharge disposition is determined.
- h. Patients who are identified as having had a stroke or TIA will receive educational materials to address pertinent issues related to their diagnosis

The care of patients identified with a Stroke or TIA is reviewed for adherence to the above guidelines. The Stroke Committee meets regularly to review data related to the above guidelines and implements changes as needed.

Related Policies: CPM 700-2a Acute Stroke Care Algorithm
CPM 700-2b Inpatient Acute Neurological Event Algorithm
CPM 700-2c Rehab Services and Discharge Planning Algorithm
CPM 700-2d Blood Pressure Management in Acute Stroke Patients
CPM 700-2e tPA for ischemic stroke
CPM 700-2f tPA dosing
CPM 700-2g CT Utilization guideline
CPM 700-2j Acute Neurological Event Algorithm For All Outpatient Clinic Patients, or Visitors
CPM 700-2k Acute Neurological Event Algorithm For All Surgical and PACU patients

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