

PURPOSE: To support the Emergency Department and Stroke Team in: 1) the immediate assessment of a patient presenting with possible stroke, (2) the Stroke Code process, and (3) the potential treatment of a stroke patient.

Patient is presenting with a sudden onset of focal neurological deficits suggestive of an acute stroke with last known well of $\leq 24h$

Triage Nurse notifies ED MD of possible stroke.
RN prepares resuscitation Stroke Bay.
ED MD immediately assesses patient's baseline function status*.

*Patients with severe comorbidities, bed bound, or with severe pre-existing cognitive impairment to a degree where they cannot communicate or recognize family members are NOT candidates for EVT or thrombolysis
Consult Neurology for uncertain cases

Determine patient's last known well or time of stroke symptom onset

Last known well $\leq 6h$

Last known well $>6-24h$

ED MD completes FAST ED / ACT FAST (LVO Screen)

Screen **positive** and/or severe motor weakness, and/or aphasia, and/or neglect

ED MD activates Stroke Code

ED MD launches order set "Initial Evaluation of STROKE for Possible Thrombolysis (STROKE CODE)"

Neurology arrives in ED or calls within 10 minutes
Neurology to assess patient before proceeding to CT

STROKE CODE PAUSE #1 (ED Resus Room Huddle)

CT/CTA/CTP RAPID

STROKE CODE PAUSE #2 (CT Room Huddle)

Patient will receive treatment

YES/UNCLEAR

STROKE CODE PAUSE #3 (Stop in Stroke Bay) (if thrombolysis/EVT candidate or unclear on decision)

Thrombolysis

RN & Stroke Lead verify dose & pump
RN administers thrombolytic in Stroke Bay

EVT Candidate

Neurology confirms Angio Room readiness

Continue with standard process and care

Refer to TIA/Minor Non-Disabling Stroke Outpatient Management Protocol, if appropriate

STROKE CODE PAUSE #1

ED RESUSCITATION ROOM HUDDLE - Facilitated by Stroke Code Lead

NAMES & ROLES: STROKE CODE LEAD SAYS IT LOUDLY

- **Stroke Code LEAD:** "I am the Sr Resident or Staff Neurologist. I will be the Stroke Code Lead. I will inform Primary ED RN of treatment decision and verify the dose and pump with Primary ED RN."
- **Primary ED RN:** "I am the Primary ED RN. I will provide nursing interventions, bring the stroke box and the IV pump."

SAFETY CHECKLIST: STROKE CODE LEAD SAYS IT LOUDLY

1. **AIRWAY** - Are we satisfied with the AIRWAY?
2. **IV ACCESS** - Do we have IV ACCESS?
3. **LABS** - Has BLOODWORK been ORDERED and SENT?
4. **WEIGHT** - Do we have a WEIGHT?
5. **CT** - Has CT been ORDERED? Is CT READY? Which CT?
6. **STROKE BOX AND IV PUMP** - Do we have STROKE BOX and working IV PUMP?
7. **IDENTIFICATION AND BELONGINGS** - Are ID STICKERS, ARMBAND and BELONGINGS with patient?

STROKE CODE PAUSE #2

CT ROOM HUDDLE

WHEN PLAIN CT COMPLETES - LEAD SAYS IT LOUDLY

"Patient is not a bleed. We need to confirm patient's weight and dosage for thrombolysis in case we decide to treat."
OR
"Patient is a bleed. We aren't going to treat with thrombolysis or EVT."

STROKE CODE PAUSE #3

STOP IN STROKE BAY

TREATMENT DECISION - LEAD SAYS IT LOUDLY

- **No Treatment** - "We aren't going to treat with thrombolysis or EVT."
- **Unclear** - "We are unsure whether we will proceed with treatment, Primary ED RN and patient can return to resus"
- **Yes Treatment** - "We will be proceeding with ..."