

Mercy Medical Center Emergency Department Algorithm for Acute Stroke

EMS must have normalized blood sugar and abnormal pre-hospital Cincinnati

Patient presents to ED with signs/symptoms of acute stroke. Identified by triage nurse as a possible stroke alert. If arriving by EMS, patient will be identified as such by pre-hospital personnel.

Triage nurse assigns room
Primary Nurse obtains accucheck blood glucose

Triage nurse or dispatch notifies charge nurse and ED physician of possible stroke alert
Charge nurse or primary nurse notifies physician of possible Stroke Alert.

ED physician confirms Stroke Alert-dispatch is notified-Stroke alert called to Stroke team.

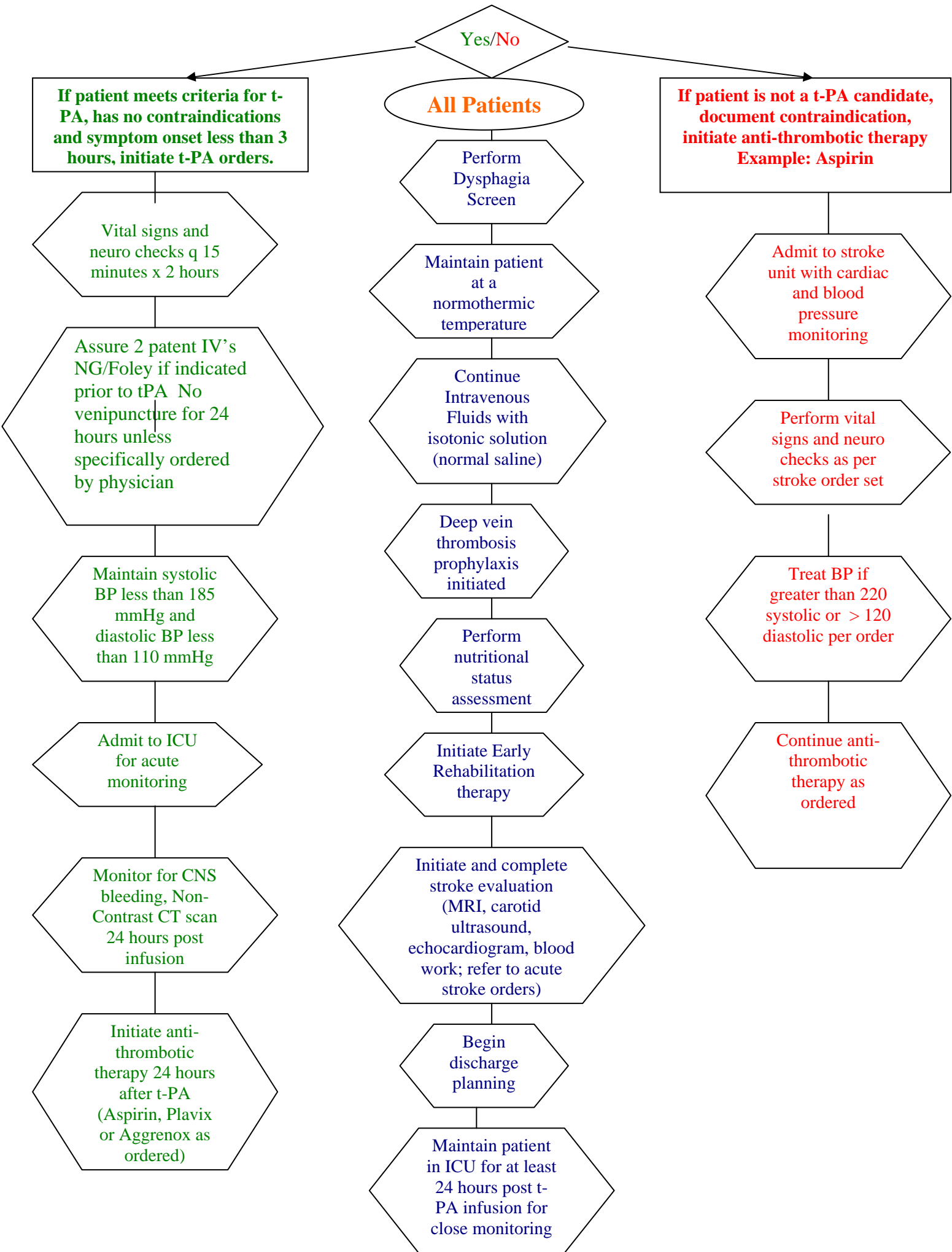
- Dr. Jacoby
- Terri Hamm
- Rita Geisinger
- Charge Nurse

IV is started with Normal Saline at 100 cc/hr, stat labs are obtained (CMP, CBC, PT/INR, Fibrinogen, glucose). Cardiac monitor, blood pressure monitor placed. O2 at 2 liters/min per nasal cannula. Educate patient and family. Treat BP if systolic >185 mmHg or diastolic >110 mmHg; treat hypotension if present. Initiate second IV site in preparation for possible thrombolytic therapy. CT is notified by back desk secretary. ECS calls for stroke alert

- CT Notified
- Stroke Panel
- CXR
- ECG
- 2 IV Sites
- NS at 100c/hr
- NIBP place q 15 minute blood pressures
- O2 2L/NC
- Dysphagia Screen prior to ANY oral intake including meds
- Maintain Normothermic Temps

Patient to CT scan accompanied by nurse (Goal time to CT is 25 minutes or less, CT results within 20 minutes of completion).

Stroke team arrives in ED, determines treatment options.



Yes/No

If patient meets criteria for t-PA, has no contraindications and symptom onset less than 3 hours, initiate t-PA orders.

If patient is not a t-PA candidate, document contraindication, initiate anti-thrombotic therapy Example: Aspirin

All Patients

Perform Dysphagia Screen

Maintain patient at a normothermic temperature

Continue Intravenous Fluids with isotonic solution (normal saline)

Deep vein thrombosis prophylaxis initiated

Perform nutritional status assessment

Initiate Early Rehabilitation therapy

Initiate and complete stroke evaluation (MRI, carotid ultrasound, echocardiogram, blood work; refer to acute stroke orders)

Begin discharge planning

Maintain patient in ICU for at least 24 hours post t-PA infusion for close monitoring

Vital signs and neuro checks q 15 minutes x 2 hours

Assure 2 patent IV's NG/Foley if indicated prior to tPA No venipuncture for 24 hours unless specifically ordered by physician

Maintain systolic BP less than 185 mmHg and diastolic BP less than 110 mmHg

Admit to ICU for acute monitoring

Monitor for CNS bleeding, Non-Contrast CT scan 24 hours post infusion

Initiate anti-thrombotic therapy 24 hours after t-PA (Aspirin, Plavix or Aggrenox as ordered)

Admit to stroke unit with cardiac and blood pressure monitoring

Perform vital signs and neuro checks as per stroke order set

Treat BP if greater than 220 systolic or > 120 diastolic per order

Continue anti-thrombotic therapy as ordered