In-Hospital Stroke Alert Protocol:

Pocket Card for Stroke Response Team Members

**GOAL: CT performed within 25 minutes from symptom onset!!!**

1. Stroke Alert initiated by calling *(number)*.
2. Primary RN records time of symptom onset if witnessed or time patient was last known without deficit.
3. Primary RN assesses ABCs and vital signs and records current vital signs.
4. Provide oxygen to O₂ saturation > 92%.
5. Primary RN notifies charge RN and remains at patient’s bedside.
6. Primary RN obtains finger stick blood sugar.
7. Charge RN assists with equipment collection and coordination of who will transfer patient to CT and notifies patient’s primary physician of patient’s status change.
8. Primary RN ensures patient has minimum 20 gauge AC IV.
9. Primary RN draws blood for testing *(color)* top, *(color)* top with gel, and *(color)* top. If female patient of childbearing age, also draw a *(color)* top.
10. Stroke Response Team responds within 15 minutes.
11. Stroke Response Team performs rapid patient assessment including NIHSS.
12. *(individual)* orders stat labs (CBC, Chem-7, PT/INR, PTT, troponin, and HCG if age appropriate), and stat non-contrast brain CT.
13. Clerk sends stat CT request and enters stat orders.
14. Primary RN prepares to accompany patient emergently to CT (with portable oxygen and cardiac monitor).
15. *(individual)* calls CT tech at *(number)* with notification that stroke patient is en route.
16. *(individuals)* transfer patient to CT *(location)* immediately after notifying CT tech.
17. Stroke Response Team communicates assessment with neurology or designee and evaluates inclusion and exclusion criteria for IV tPA and determines if patient is candidate for treatment (refer to institution’s inclusion/exclusion criteria).
   - If IV thrombolysis is to be given, Stroke Response Team member notifies (individual) (number).
   - Send thrombolytic orders to pharmacy STAT and send runner for drug if needed.
   - Primary RN establishes patient’s weight.
   - Stroke Response Team or designee will assist with tPA administration.
   - If IA/mechanical thrombolysis is indicated, activate endovascular team (number).

18. A member of the Stroke Team and the (individual) will remain at patient bedside until patient is transferred to the ICU or endovascular suite.

19. Once IV tPA is started, monitor vitals and neurological assessment every 15 minutes for two hours, then every 30 minutes for 6 hours, then hourly.


Comments
In-Hospital Stroke Alert Protocol was designed to be individualized to meet the needs and resources of the individual hospital. Laminated pocket cards with the protocol can be carried by members of the in-hospital stroke rapid response team.

Depending on delays identified, the order of the protocol may be modified.

As an example, if placement of IV or blood draw is delaying time to CT scan then these steps may be performed after CT scan is complete.

Individual with authority to order initial laboratory and imaging studies may vary. Delays in reaching primary attending can be overcome by institutional protocol which allows designated tests to be ordered automatically for all stroke alerts.