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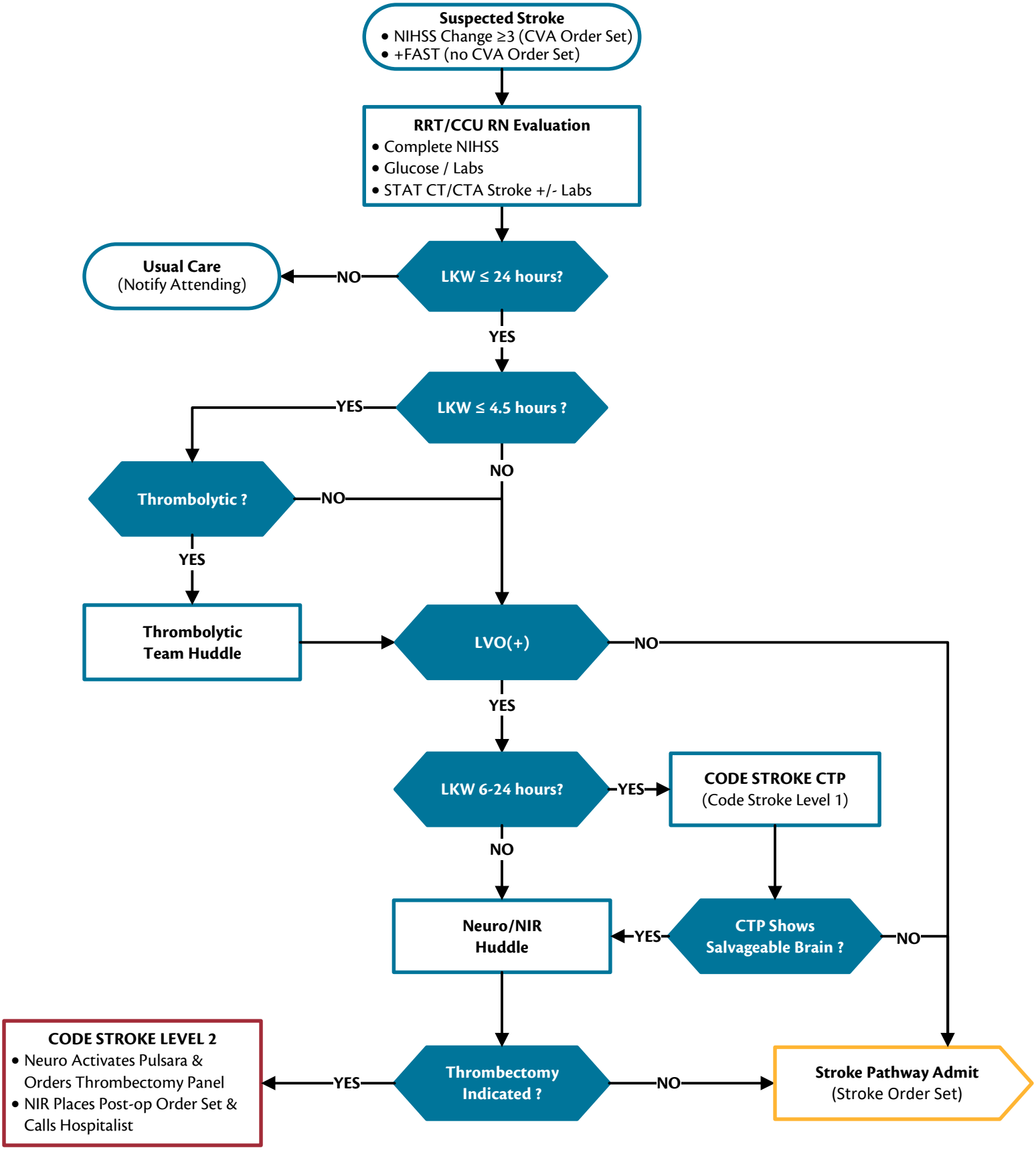
Stroke: Inpatient Management



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Stroke – Inpatient Management

Staff RN: Call Rapid Response x1999 or CAR/STAT RN(CCU) Immediately

0 – 5 Minutes

PATIENTS ON A STROKE PATHWAY/ORDER SET

- **Recheck NIHSS**, if >3 point change call Rapid Response CCU RN and call CAR/STAT RN immediately

ALL OTHER PATIENTS – PERFORM FAST EXAM

Face	Droop on one side, unable to smile evenly
Arms/Legs	New onset weak/numb limb/side
Speech	Slurring, difficulty word finding, mute, sudden confusion.
Time	Time is Brain!

- ❑ Obtain "last known well" (LKW): Time when last at baseline
- ❑ Measure blood glucose & treat
- ❑ Initiate ACLS monitoring, place O2
- ❑ Record/verify patient weight
- ❑ Check for IV patency (18-20 gauge, 2 lines ideal) & have NS ready

	Physician / Hospitalist	CAR/STAT/CCU RN	Staff RN	Admitting FP Resident
5 – 15 Minutes		• Assess patient & review history, labs & LKW • If not done w/in 24hrs, order indicated labs (CBC, Coags) • **Complete NIHSS** IF POSSIBLE STROKE: • **Initiate "Inpt Stroke Case" on Pulsara, include room number** • **Order STAT Stroke CT/CTA** w/ signs/symptoms & Neurohospitalist name	• SBAR to RRT • Document per RRT • Page Attending LIP or Call Hospitalist (Volte)	• **Verify LKW** • **Complete and document inclusion/exclusion for IV thrombolytic in EPIC** • Explain management of suspected stroke to patient and family
15 – 25 Minutes	• Confirm history, labs, & LKW • Meet in CT discuss plan with Neurologist, including **IV thrombolytic administration decision** • Order IV thrombolytic PRN • Order CTP if LVO+ & LKW>6 hrs	• Bring patient to CT, POCT creatinine if no creatinine within 24 hrs • SBAR to Hospitalist	• Continued communication with patient and family PRN • Remain available to provide support to RRT	• **Complete & document NIHSS** • Meet patient and CAR/Staff RN/LIP to CT/CTA • Update via Pulsara regarding: LKW, incl/excl thrombolytic, & NIHSS

25 – 45 Minutes	• **If thrombectomy indicated, Neurologist will:**
	  • **Discuss with NI on call & update Pulsara team with "Stroke Level 2 Team"**
	  • **Order "thrombectomy panel" assigning NI on call as the attending**
		• Facilitate thrombolytic order/dosing/administration
		• If thrombectomy indicated, work to coordinate plan & facilitate bed placement
			• Remain available to provide support to RRT for thrombolytic bolus/infusion, handoff to angio/CCU	• Work to remove any barriers to rapid Tx w/ thrombolytic +/- EVT
				• **Provide IV thrombolytic and/or thrombectomy education to patient and family**

45+ Mins	• Speak to family • If Transferring, Report/sign out to Intensivist • If getting thrombectomy, post EVT receiving Hospitalist	• Accompany patient to appropriate unit & provide bedside handoff		• Direct family to new patient location if needed • Explain events to family

Tell Operator this page is Urgent for Suspected Stroke*Harborview UW
Admitting Hospitalist: **(206)969-5253**
Transfer/Consult Center: **(888)731-4791**
Admitting Family Practice Resident: (**206)969-2660**

NIH Stroke Scale

NIH STROKE SCALE ITEM	FUNCTION	RATING
1a. LEVEL OF CONSCIOUSNESS (3 only if no movement or reflex only) ➡ Requires repeated or painful stimulation to move = 2	Alert Arousable by minor stimuli Not alert, obtunded No response or reflex only	0 1 2 3
1b. LOC QUESTIONS (aphasic, stuporous = 2) ➡ Ask month, age (intubated, trauma, language barrier = 1)	Both answers are correct One answer is correct Both incorrect	0 1 2
1c. LOC COMMANDS May demonstrate, take first attempt. ➡ Open/close eyes, make fist/let go Credit attempt with weakness.	Performs both correctly Performs one correctly Performs neither correctly	0 1 2
2. BEST GAZE ➡ Eyes open; patient follows examiner's finger or face If unable, perform oculocephalic (Doll's eyes)	Normal Partial gaze palsy Forced deviation/total paresis	0 1 2
3. VISUAL ➡ Use fingers or visual threat to patient's upper & lower quadrants. Able to see both simultaneous fingers? No = extinction = 1. Hemianopia = loss of one half of visual field.	No loss Partial hemianopia (asymmetry) Complete hemianopia Bilateral hemianopia, blind	0 1 2 3
4. FACIAL PALSY ➡ Show teeth, raise eyebrow and squeeze eyes shut Complete = No facial movement in upper & lower face = 3 Unresponsive patient – use painful stimuli, score grimace.	Normal Minor asymmetry, droop Lower face paralysis Complete paralysis of upper & lower face	0 1 2 3
5a. MOTOR ARM-LEFT ➡ Extend arm, palm down, 90 degrees when sitting, 45 degrees if supine and score drift/movement Hold for 10 seconds. Amputation = UN	No drift Drift Some effort against gravity No effort against gravity No movement	0 1 2 3 4
5b. MOTOR LEG-LEFT ➡ Elevate extremity 30 degrees when lying down and score drift/movement. Hold for 5 seconds. Amputation = UN	No drift Drift Some effort against gravity No effort against gravity No movement	0 1 2 3 4
6a. MOTOR ARM-RIGHT ➡ Extend arm, palm down, 90 degrees when sitting and 45 degrees if supine. Hold for 10 seconds. Score drift/movement.	No drift Drift Some effort against gravity No effort against gravity, limb falls No movement	0 1 2 3 4
6b. MOTOR LEG-RIGHT ➡ Elevate extremity 30 degrees when lying down and score drift/movement. Hold for 5 seconds.	No drift Drift Some effort against gravity No effort against gravity No movement	0 1 2 3 4
7. LIMB ATAXIA ➡ Finger-Nose, heel down shin, both sides. Absent in paralyzed or aphasic.	Absent Present in one limb Present in two limbs	0 1 2
8. SENSORY ➡ Pin prick or noxious stimuli to face, arm, trunk, and leg – compare side to side. Bilateral loss in brainstem stroke = 2	Normal Mild/Mod loss (less sharp/dull) Severe/Total (no sensation)	0 1 2
9. BEST LANGUAGE ➡ Name items, describe picture and read sentences on NIHSS flipchart. Intubated patient can write.	No aphasia Mild-moderate aphasia Severe aphasia Mute/global aphasia	0 1 2 3
10. DYSARTHRIA ➡ Evaluate speech clarity by patient repeating words listed on flipchart. Intubated = UN	Normal articulation Mild-moderate slurring Severe, unintelligible, mute	0 1 2
11. EXTINCTION AND INATTENTION ➡ Use information from prior testing to identify neglect or double simultaneous stimuli testing. Only scored if present.	No neglect Partial neglect/inattention Profound neglect	0 1 2