Inpatient Acute Stroke Alert Pathway

**RN/Clinical Staff** suspects stroke symptoms in an inpatient

**RN** calls 662-2345, option 1 (for medical emergency) and states “Possible Inpatient Stroke” AND notifies the patient’s PRIMARY TEAM of concern for stroke

**PRIMARY TEAM:**
- Comes to the bedside STAT
- Assesses the patient
- Helps provide history to the N.App

**REMIS pages:**
"Possible Inpatient Stroke, Room ___.” APP to call xxx-xxx:
- Neurology APP 580-5621 and Neurocritical Care APP 741-3091 (N.App = either going forward)
- 7AM – 7PM Neurology APP responds
- 7PM – 7AM Neurocritical Care APP responds

**N.App:**
- Calls back to obtain brief history. Goal Page-to-Call back: within 5 min (call back may be done by surrogate, such as a nurse holding the pager, if N.App is in the middle of another medical emergency)
- Assesses the patient, including performs an NIHSS. Goal Page-to-APP assessment: 10 min.
- Reviews clinical history and available data with help from the patient’s RN & the PRIMARY TEAM.
- If an acute stroke is suspected: N.App calls REMIS and activates an INPATIENT ACUTE STROKE ALERT and provides a call back number
- Reviews recent labs (INR, platelets, Cr) and informs phlebotomist of what needs/does not need to be drawn
- Enters orders into the Inpatient Stroke Order Set including a Neurology Consult, any needed labs and a STAT CT/CTA “with perfusion” if symptoms consistent with large vessel occlusion (LVO)

**REMIS pages:**
"Inpatient Acute Stroke Alert, Room ___. Neurologist to call xxx-xxxx STAT”
- On-call Neurologist
- Phlebotomist
- CT technologist
- Pharmacist
- Radiology Resident
- Nursing Supervisor
- ED Coordinator
- SCU Coordinator
- Cardiac Access Coordinator
- Float Nurse
- R2 Charge Nurse
- Stroke Program Manager
- Stroke Data Coordinator

**Neurologist** calls back within 5 minutes and speaks with the N.App. Neurologist is at bedside ASAP, maximum 45 min from page. This may be following the CT/CTA via Telestroke in an ED Critical Care bay if 7PM-7AM.

**Decision regarding acute management is made following imaging, labs and Neurologist assessment**

**TPA/IAT not indicated**
- Patient is either transported back to original room or change in bed placement is made as clinically indicated with ongoing management by the PRIMARY TEAM
- If the pt is not already on a service that manages patient in an ICU, transfer of care to an ICU service requires an attending-to-attending phone call, and the PRIMARY TEAM will maintain management of the patient until the ICU team is able to assume care

**TPA indicated**
- Neurologist or N.App orders tPA and calls Pharmacy STAT line 662-3333 to request tPA delivery to the ED
- Pt is moved from CT to the ED Critical Care area for initiation of tPA/further monitoring
- Pharmacist brings tPA to the ED
- ED RN administers tPA, Goal Alert-to-needle 60 min.

**IAT indicated (with or without tPA)**
- Neurologist contacts the Neurointerventionalist to arrange for the procedure as soon as a LVO is suspected (by clinical and/or imaging data)
- The Neurointerventionalist activates the IR staff and Anesthesiologist if they agree that IAT is indicated
- Patient is transferred to the IR suite ASAP, Goal Alert-to-groin-puncture 110 min. This will be after the initiation of tPA in the Critical Care area if tPA is also indicated

**Patient disposition:**
- If ICU bed available and no IAT planned, pt is transported to ICU to complete tPA infusion
- If ICU bed is NOT available or IAT is planned, pt is kept in the ED Critical Care area and the ED RN monitors patient post-tPA until an ICU bed is available or the pt is taken to the NIR suite, respectively

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LVO = large vessel occlusion
IAT = intra-arterial therapy