

Acute Stroke Patient Process

Aurora Medical Center Washington County



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Aurora Medical Center Washington County

- Rural hospital licensed for 71 beds
- Staffed for 34 beds
- Accredited by DNV
- Magnet Certification September 2019
- State certified as a Level III Trauma Center
- Telehealth Services





Our Stroke Journey

January 2017 – Acute Stroke Ready Program started

August 2017 – Obtained Acute Stroke Ready Certification

August 2019 – Recertified as Acute Stroke Ready Joint Commission

July 2020 - first DNV Survey with Phase 2 January 2021

July 2021 – Anticipating second survey with DNV

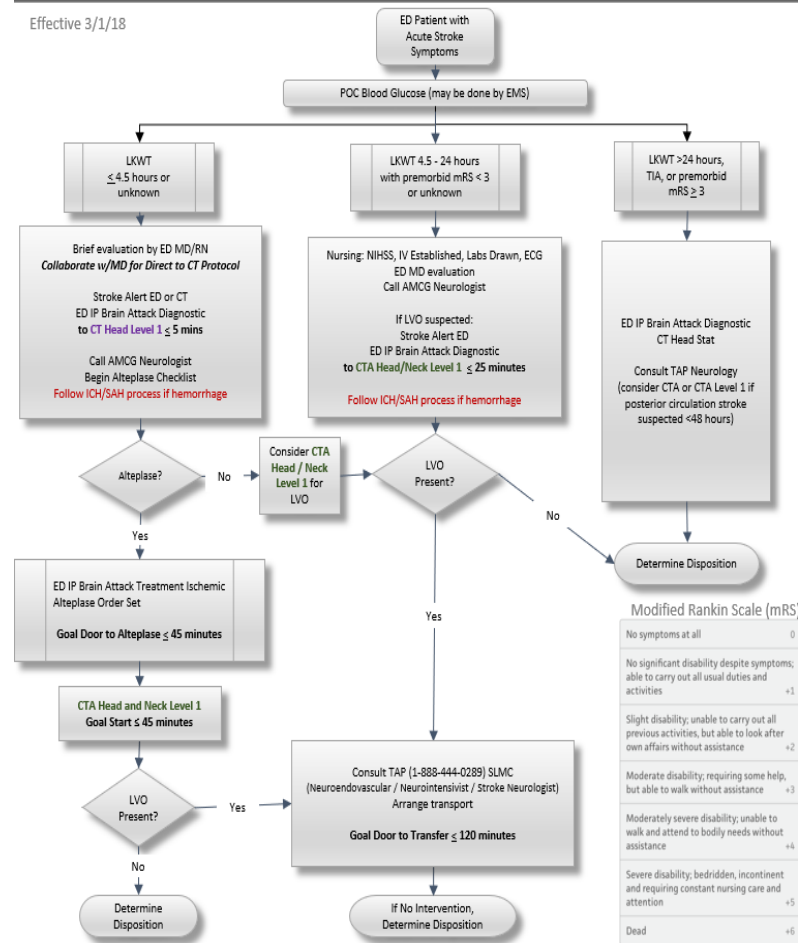
New Process Implementation

- Develop different medical emergency alerts
 - Stroke Alert to CT
 - Stroke Alert ED
 - EMS to CT
- Collaboration with Hospital Departments
 - Diagnostic Imaging, Patient Access, ED physicians and nurses, Lab
- Education to Hospital Departments and EMS
 - Process changed sent to area EMS
 - Staff Meeting Reviews
 - Mock

EMS to CT

- Focus was patients with a LKWT <24 hours
- EMS direct to CT in 2018
- Private Vehicle and EMS direct to CT in June 2020

Effective 3/1/18



Updated: 1.3.2018

AMCWC ED Acute Stroke Process

Suspect Large Vessel Occlusion (LVO)

if any of the following are present:

- Cortical Signs Present (gaze deviation, aphasia, neglect)
- NIHSS >5
- Dense Sign of Thrombus on CT

Consider Posterior Circulation Infarct

if TWO symptoms from List A or ONE symptom from both List A and List B

List A

Dizzy, ataxia, unsteadiness, visual changes, double vision (including pupil changes)

List B

Focal weakness, slurred speech and aphasia

Absolute CTA contraindication = pre-existing anaphylactic response to dye

Provide Acute Stroke Neurologist with the following information at time of consult:

1. LKWT
2. Neurological Findings / Deficits
3. Premorbid mRS
4. Anticoagulation

For any patient with recent or current use of Dabigatran, Rivoroxaban, Apixiban, or Edoxaban, use Eligibility Criteria Guidelines to determine IV alteplase eligibility

Assessments

- Upon return from CT
 - NIH is completed simultaneously with Teleneurology
 - Vital Signs and neuro checks are completed per our protocol
 - Dysphagia is completed on all stroke patients

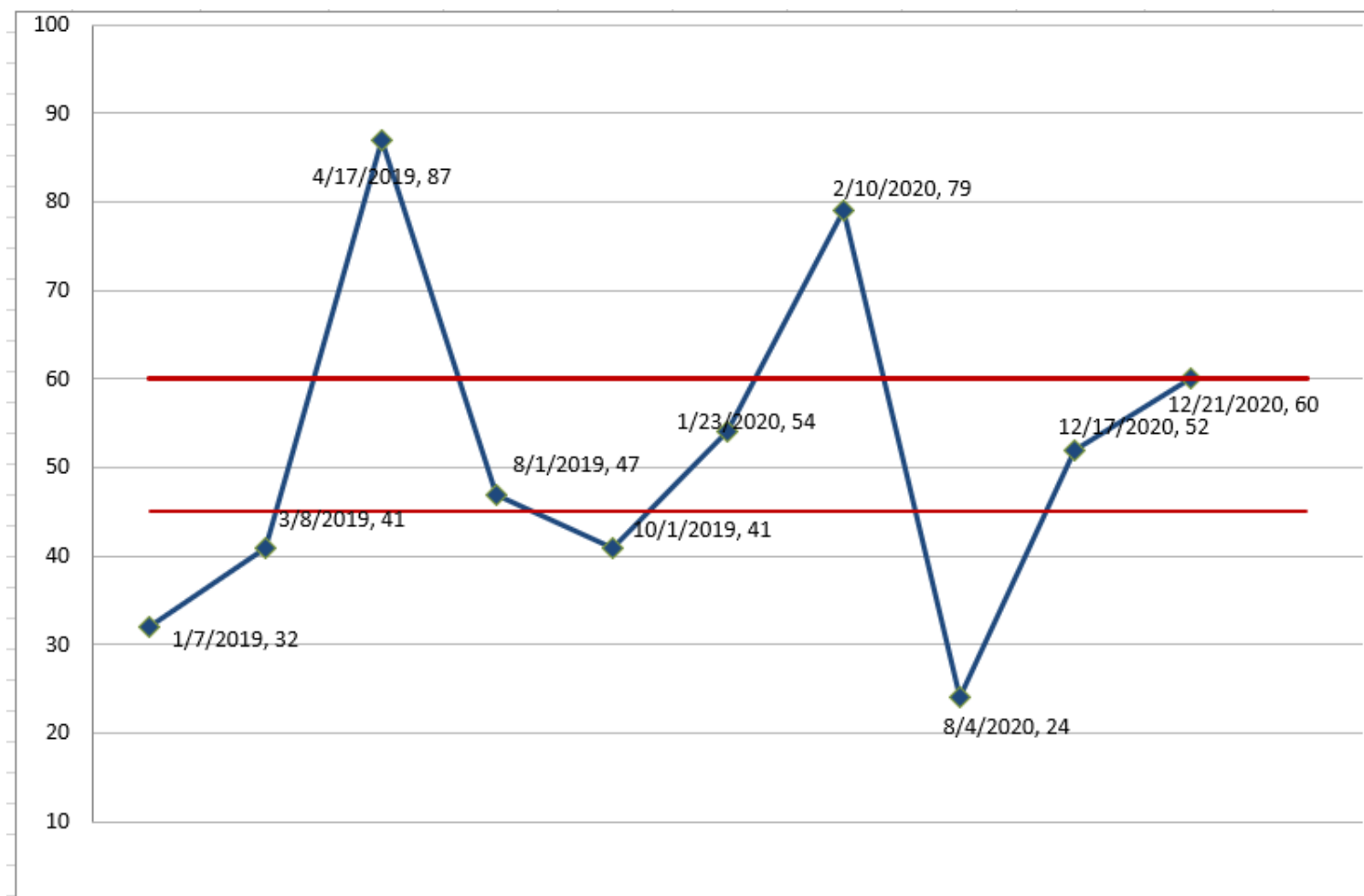
Diagnostics

- All patients have additional labs beyond glucose
- Door to CT start < 25 minutes
- Door to CT result < 45 minutes
- CTA end time to CTA result <60 minutes
- PT/PTT result median of 45 minutes from order to result

Order to Lab Results (median)	≤45 min	28 min	38 min	29 min	n/a	36 min	47 min	51 min	54.5 min	38 min	n/a	62 min	44 min
Imaging initiated ≤ 25 minutes from arrival (CT Head)	≥ 90%	100%	100%	100%	n/a	100%	100%	66%	100%	100%	n/a	100%	75%
Imaging resulted ≤ 45 minutes of arrival (CT Head)	≥90%	100%	100%	100%	n/a	100%	100%	66%	100%	100%	n/a	100%	100%

Thrombolytics < 45 minutes

- Focused on the “why” with staff
- Direct Door to CT
- Involving Teleneurology early
- Having Pharmacy at bedside
- Administer hypertensive medications early
- Staff follow up for all stroke patients



Transferring Out

TIAs

- Discharge and follow up OP TIA Clinic
- Transfer to Primary Stroke Center

CVAs

- Transfer to Primary Stroke Center

Alteplase Infusions

- Transfer to Primary Stroke Center

Endovascular/LVO

- Transfer to Comprehensive Stroke Center

Hospice/Comfort Care

- Admit at AMCWC
- Discharge with Hospice

Door to Door

- **Coordination with Tertiary Access Program**
 - Bed Constraints for non Alteplase and LVO patients
 - Teleneurology assisting with LVO coordination
- **EMS transport delays**

Time from arrival to transfer (median) in minutes	<120 min	176	213.5	177	101	158	215	233	131	147	n/a	190	166.5	176
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Data

- Quality Data Analysis enters required data points into Get With the Guidelines (GWTG) for Acute Stroke Ready
- Partnership with Coverdell
- Reabstraction completed quarterly

Questions