WRHN @ Midtown
Waterloo Regional Health Network

FAST Stroke Screen positive:

☐ One or more symptoms from Face, Arm, Speech and

☐ LAST SEEN NORMAL Time <24 hours

FACE	ARM	SPEECH	TIME
☐ Right droop ☐ Left droop _____ ☐ Normal	☐ Right weak ☐ Left weak _____ ☐ Normal	☐ Slurred _____ ☐ Normal	☐ Less than 24 hours _____ ☐ Outside window

Physician will assess EVT Eligibility

1. Deficits are NOT pre-existing (mild deficits that are now worse are acceptable as true deficits)
2. Onset of symptoms or last seen normal less than 24 hrs
3. Living at home independently with only minor assistance—must be independent with hygiene, personal care tasks, walking (walking aids are acceptable)
4. Patient does NOT have stroke mimics: seizure preceding symptoms, Hypoglycemia = glucose less than 2.8 mmol/L, Active malignancy with brain lesions

- Try and use clues to guess time last seen well—did someone talk to or call patient?
- For suspected Wake-Up symptoms, did patient get up overnight? Were they normal when first getting up?

ACT—FAST Stroke screen

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ED MD to assess patient's baseline functional status

Is the patient independent?

(NOT wheelchair or bed-bound or demented)

"ARM" (one-sided arm weakness)

Position both arms at 45 degrees from the horizontal with elbows straight

POSITIVE TEST

One arm falls completely within 10 seconds of being held up.

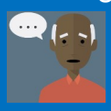
<u>For patients that are uncooperative or cannot follow commands:</u>

Witness minimal or no movements in one arm & movement in the other

Proceed if Positive

If RIGHT ARM is weak

"CHAT" (severe language deficit)



Ask the patient to repeat
"You can't teach an old dog new tricks"
OR perform simple tasks
("make a fist", "open and close your eyes")

POSITIVE

Mute, Speaking incomprehensively, unable to follow simple commands

If LEFT ARM is weak

"TAP" (gaze and shoulder tap test)

Stand on patient's weak side & call name

POSITIVE TEST—Consistent gaze to the RIGHT

OR

Tap shoulder & call name

POSITIVE TEST—does not quickly turn head and eyes to you

Proceed if Positive

OBTAIN LATE WINDOW STROKE IMAGING
(CT, CTA and CTP RAPID)

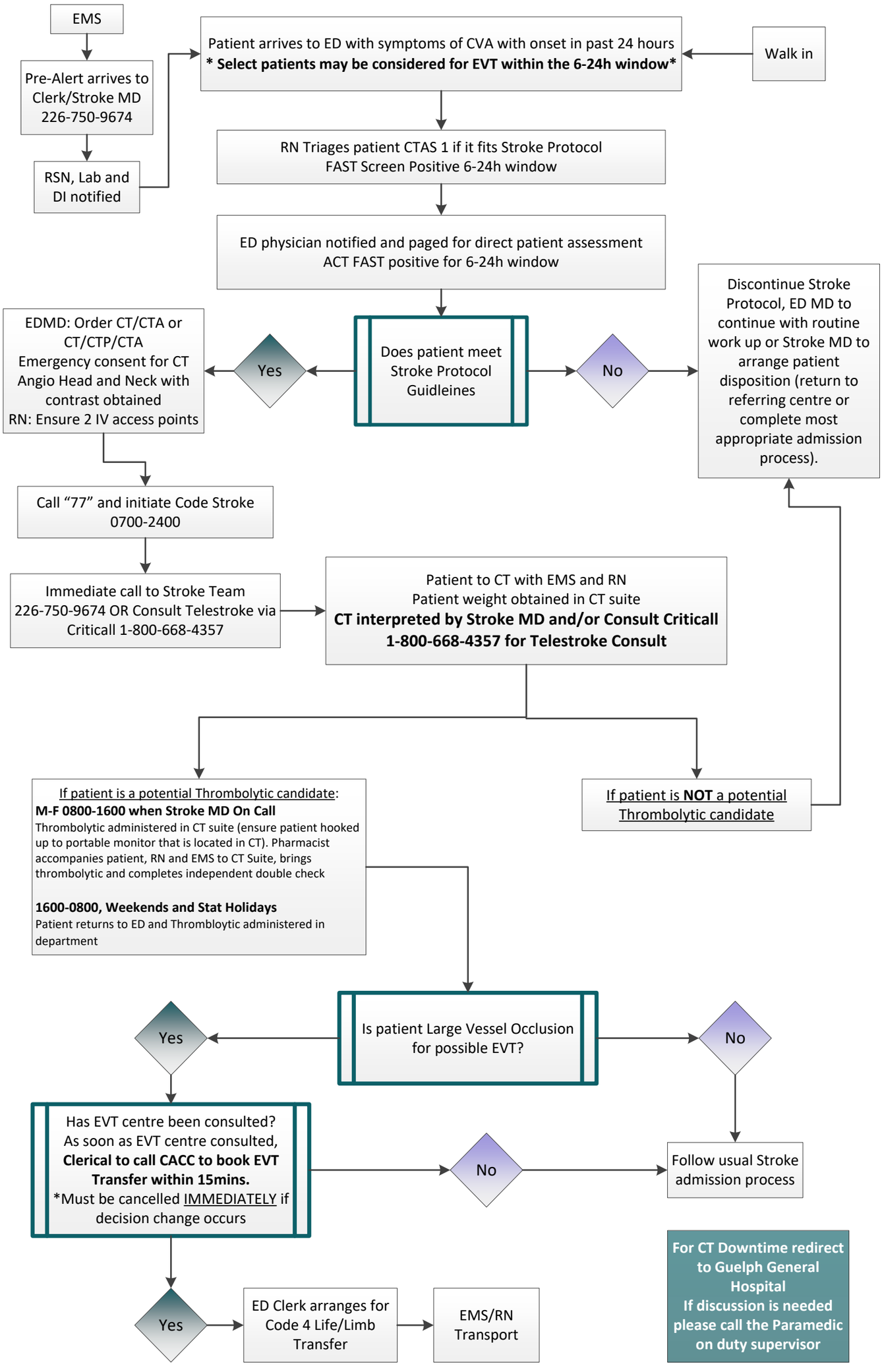
- Obtain Emergency Consent
- Page Stroke Team

RAPID Positive?

Activate Code Stroke

Stroke Team to call Criticall for Telestroke Consult

WRHN @Midtown ED Hyperacute Stroke/EVT Algorithm



April 20 2023 v8 cm

See Appendix for Roles/Responsibilities

Appendix: Roles and Responsibilities

Role/Discipline	Responsibilities
Switchboard	1. 0700 Stroke Phone programmed to auto-forward calls to Stroke MD On-Call
EMS	1. Complete pre-alert by calling 5818 2. Pre-alert to Stroke MD and provide report on: • Prompt Card Findings • Time Last Seen Normal • LAMS Score • Residence – LTC, RH • ETA • List of Antiplatelet, NOACs, if available > Coumadin > NOACS – Rivaroxaban, Apixaban, Edoxaban 3. Ask patient family for a cellphone contact number, on scene and provide to clerical upon arrival to ED 4. Ensure 2 IV access points, when able 5. Transfer patient to CT on EMS stretcher with Primary RN 6. Transfer patient from EMS stretcher to Stroke stretcher and Stroke stretcher to CT bed, in CT suite 7. Complete patient TOA 8. Accompany patient on transfer if required
Clerical	1. Look up Stroke On Call and Telestroke status on Petal and post on Acute Care white board. 2. Receive pre-alert call from EMS and record HCN, patient name, symptoms and onset, LVO Clinical Screen Positive or Negative and ETA, transfer call to Stroke MD phone 226-750-9674 3. Call Resource Nurse to relay information 4. Notify below departments of stroke patient ETA 5. Pharmacy x 2246 **(M – F 0800 – 1600; do not call outside of noted hours)** 6. CT x 3828 7. PageGate LAB 8. Complete patient Quick Registration, add Encounter, if not found. Add Person in to system 9. Assign Resus. Doctor in FirstNet 10. Register patient and print out labels/stickers/armband 11. Orders: Stroke Labs in HUC QC 12. Label a CTA Consent form with Patient Sticker 13. If patient is older than 65 years, Print ODB or Clinical Connect medication list 14. On patient arrival, page EDMD to Acute Care for Stroke Protocol 15. Call “77” and initiate Code Stroke, if required 16. Enter CT orders as directed by EDMD 17. Notify CT of incoming patient prior to leaving Acute Care area, if required **For Telestroke:** 18. Call Criticall for Telestroke Consult (1-800-668-4357) 19. If indicated by MD, call CACC to pre-book EMS transfer to arrive within **15 minutes.** If change in decision is made re: EMS transfer, must CANCEL immediately. 20. Monitor fax machine for Telestroke Consult note to arrive and scan in to patient chart **For EVT**: 21. Call Criticall (1-800-668-4357) 22. Arrange Code 4 Life/Limb Transfer as per the Stroke Endovascular Checklist for Transfer 23. Obtain Emergency Department – Routine Transfer Orders Acute Stroke with/without Thrombolytic, have physician sign, scan into chart, and give original to transfer nurse
Resource RN	1. Complete initial triage assessment when patient has arrived by EMS 2. If walk in, determine if Stroke Protocol criteria is met 3. Assign patient room; Telestroke rooms (2, 3, 4, 5, 6, 8, 9, 10, 11 and 12 ONLY)
Primary RN	1. Ensure patient room is prepared 2. Bring Telestroke camera to bedside 3. When patient arrives, obtain 2 IV access sites if not completed 4. Accompany patient to CT 5. Obtain patient weight in CT suite 6. **Monday - Friday between 0800 – 1600**: if thrombolytic administered in CT suite ensure independent double check of medication and administer medication as ordered. **Patient must be hooked up to portable monitor labeled LOANER STROKE MONITOR found in CT department, Bay 2; prior to administration of medication** 7. Accompany patient back to the ED 8. Place patient in gown and hook up to monitor 9. If transfer required confirm receiving facility, prepare transfer equipment and medications, and accompany patient on transfer. ⚐ Note: While a Foley catheter is required for EVT, it is not a priority over starting a thrombolytic

Pharmacist	1. **Monday - Friday between 0800 – 1600**, if thrombolytic indicated ➢ Bring thrombolytic to CT suite and prepare. ➢ Pharmacist will provide independent double check ⚐ Note: Pharmacy to assist with above when present, when pharmacist is not present, a second RN will assist with preparation and/or perform independent double check as required.
ED Physician	1. Complete patient assessment on arrival to ED, determine if Code Stroke needs to be initiated 2. Order CT/CTA or CT/CTP/CTA 3. If required, obtain emergency consent for CTA head and neck with contrast 4. Consult Stroke MD or Telestroke **For EVT**: **5. If patch to EVT centre, inform clerical to call CACC to pre-book EMS transfer** **6. If change in decision, inform clerical to cancel the EMS transfer immediately** **For ED Telestroke Coverage**: 7. May receive calls from SMGH and CMH for Stroke Protocol Transfers
Stroke MD/Telestroke	**If EDMD not involved**: 1. Complete immediate patient assessment 2. Order CT/CTA or CT/CTP/CTA 3. If required, obtain emergency consent for CTA head and neck with contrast **For EVT**: 1. Consult Criticall **2. If patch to EVT centre, inform clerical to call CACC to pre-book EMS transfer** **3. If change in decision, inform clerical to cancel the EMS transfer immediately** **If Stroke Protocol criteria not met**: 1. Arrange patient disposition (return to referring centre or complete most appropriate admission process)
Environmental Services	1. Clean and return portable monitor labeled LOANER STROKE MONITOR to CT, Bay 2 immediately after patient has been connected to the room monitor in the Emergency Department 2. Clean Stroke Stretcher and return to the CT hallway