Please act quickly to initiate appropriate assessment
Intravenous rtPA and/or Endovascular Thrombectomy (EVT) can significantly reduce the effects of stroke if given to appropriate stroke patients within 6 hours of stroke onset. The earlier treatment is given, the greater the potential for recovery.

**Signs of Stroke**
- FACE: Is it Drooping?
- ARMS: Can you Raise Both?
- SPEECH: Is it Slurred or Jumbled?
- TIME to page Service On-Call STAT

**Process for the Internal Activation of the Acute Stroke Protocol**

1. **Sudden onset of Signs of Stroke**
2. **Adult Inpatient**
   - Page Resident or Attending Service On-Call STAT
3. **Paediatric Inpatient**
   - Page Paediatric Intensive Care Service Attending On-Call & Senior Resident STAT
4. **Service On-Call Resident or Attending Physician**
   - Physician determines if patient meets criteria to activate Acute Stroke Protocol
   - Admitting notified. Need to maintain existing bed until treatment decision.
5. **YES**
   - **Prepare patient transfer to CT Suite**
   - **Dx: Ischemic Stroke?**
     - Intravenous rtPA not indicated
   - Intravenous rtPA given in CT Suite If EVT candidate transfer to IVR
8. **NO**
   - **Consider neurosurgery consult**
   - Treatment plan in consultation with attending service
   - **Return to home unit**
   - **Appropriate Critical Care Unit as per Patient Needs**

**Note:** Acute Stroke Protocol packages and rtPA are kept in ED, D4ICU, CSU, Cath Lab and RACE Team

**Nursing support will be provided from RACE Team as required.**

CSU and Cath Lab will manage their own internal stroke protocols Monday to Friday 0800-1600 hrs only.

**KGH Outpatients & visitors** who develop signs and symptoms of stroke will go to the ER.

**Exceptions are:**
1. **(1) Cardiac Catheterization Lab** patients will usually go to CSU;
2. **(2) PACU, post op OPPU & SDAC** patients will usually go to D4ICU. (Nursing support as noted above)

**Preparation of internal stroke patient for CT scan and for rtPA administration and/or EVT:**

**RN Responsibilities:**
- Recognize the signs of stroke.
- Act quickly: be mindful that time is BRAIN.
- Notify the Attending Service stat and communicate the patient’s signs of stroke.
- If Attending Service activates stroke protocol, prepare the patient:
  - Monitor vital signs and stroke scale using Canadian Neurological Scale, cardiac and SpO2 monitoring, glucometer reading, change to gown, remove jewelry on ears and neck/face.
  - Blood work (CBC, PT/INR, PTT, lys, urea, creatinine, glucose, troponin, TSH packed red blood cells); establish 2 IV lines (18 Gauge needle in Right Arm to permit use of high injection velocity used in CT angiography) unless contraindicated. rtPA requires a dedicated IV line.
- Accompany to CT Scan Suite.
- +/- IV rtPA administered in CT Scan Suite.
- If EVT candidate, insert Foley urinary catheter if ordered.
- Continue monitoring vital signs and neuro status q 15 min.
- Communicate with critical care unit charge nurse regarding bed transfers if patient receiving rtPA and/or EVT.
- Contact Manager or the Administrative Coordinator to arrange RACE nurse coverage if needed.
- Assist in transport and transfer care to receiving critical care unit nurse and/or IVR nurse (if EVT).
- Implement Ischemic Stroke Thrombolysis/EVT Order Set.
- Implement Ischemic Stroke Collaborative Care Plan.

**Questions? Contact:**
- Stroke Specialist Case Manager x 2830/vocera
- Clinical Learning Specialist, Neurosciences x 4083/vocera
- Administrative Coordinator after hours

Revised February 16, 2018