ASP Activation Changes (Working Document)
Effective April 25, 2017

1. Dispatch/paramedics advise ED that they have a patient under the Acute Stroke Protocol
    i. ER staff must activate ASP through switchboard
    ii. Charge needs to notify registration.
    iii. When receiving patch from paramedics, be sure to ask if patient has IV access.
    b. If patient walks into ED, perform rapid triage with recognition of stroke symptoms & initiation of Acute Stroke Protocol by ED physicians.
2. Prior to patient's arrival, the RN will have portable monitor ready (including cardiac monitoring), IV initiation/blood draw equipment, as well as the ASP package.
    a. Equipment can be kept near the ambulance triage area/offload area.
3. Upon arrival, the patient needs to be registered immediately and CT needs to be notified of arrival.
    a. **An ambulance triage must occur at this point by a triage-trained nurse**
4. Rapid handover from paramedics to Stroke Team
5. Assessment by the stroke team will occur using NIHSS (done by physicians).
    a. Stroke Team Physicians will start the assessment on the left side of the patient, leaving the right side free for IV initiation by the nurses.
6. RN must establish at least one large bore IV (preferably to the right ACF) if the patient does not have IV access prior to arrival.
    a. 2 large bore IV's are recommended if able.
    b. If IV access is difficult, advise physician prior to leaving department.
7. Draw Bloodwork – tubes available in ASP packages for CBC, electrolytes, urea, creatinine, glucose, INR, PTT, troponin & pregnancy test (βHCG) if indicated.
    a. Waiting for blood work results should not delay treatment with IV tPA +/- EVT unless there is a specific clinical reason. Blood work drawn prior to CT scan is physician dependant.
8. When possible obtain INR using Point-of-Care (POC) device. This skill is not done by ER RN.
9. RN must also switch the patient over from the paramedic's monitor to a portable ED monitor (preferably a monitor on wheels as the paramedic's stretcher is too small for additional equipment).
    a. Patient to remain on EMS stretcher until patient is transferred to CT

Synchronous (steps 4–9)

10. ED RN to obtain IV tPA from Omnicell cart.
11. Transport to CT department immediately. ED stretcher, monitor, IV pump, transport kit, and tPA from Ominicell all taken to CT department.
    a. New target is 10 minutes from ED door (arrival) to CT scan. The RN must follow patient with an ED stretcher.
12. Neurologist initiates process for consent for thrombolysis +/- thrombectomy.
13. Prior to CT, remove jewellery and dentures. Place patient on CT Table using CT transfer board.
    a. Paramedic(s) at this point give handover and story to the ED nurse in CT, while the stroke team monitors the patient.
        i. If ED RN feels report is not appropriate at this time, they can ask EMS to stop in ED and give report to another RN in the department
14. Stroke Team informs ED RN if candidate for IV tPA. Stroke Team mixes tPA +/- prepares bolus. Neurologist monitors patient while ED RN prepares tPA infusion in the CT preparation area. Neurologist will either instruct ED RN to program the IV pump for patient to receive the bolus followed by infusion or Neurologist administers tPA bolus. Patient is connected to infusion pump in CT suite. ED RN documents time bolus was administered & tPA infusion was started. If tPA not given, ED RN will return tPA to ER Omnicell.
15. Patient is placed on ER stretcher after CT and transferred into CT Prep Room. Neurologist will instruct ED RN to insert second IV if not in place. Stroke Team will inform ED RN if potential candidate for EVT. If patient is not an EVT candidate, ED RN and Stroke Team transfer patient back to ED.
16. Stroke Team contacts IVR if potential candidate for EVT.

SAMPLE

17. If patient is an EVT candidate-ED RN, Stroke team, and/or IVR RN prepare patient: continue on portable monitor, remove clothes and insert foley catheter (equipment in CT prep room). ED RN returns to ED after report given to IVR nurse.

Upon return to ED from CT the following needs to occur:

- ED ER returns tPA to Omnicell if tPA not given
- If patient is not EVT candidate, continue to monitor patient in ED
    a. CNS & BP q 15 minutes during IV tPA infusion
- Patient changed into gown if not already done
- Baseline nursing assessment completed
- Keep patient NPO until swallowing screen (STAND) is done

ED RN ASP CHECKLIST:

- ☐ ASP activated through switchboard
- ☐ Registration notified
- ☐ Prepare equipment:
    - IV access/blood draw supplies
    - Monitor on wheels
    - Stretcher & IV pump to follow patient to CT
    - ASP package
- ☐ Patient arrival:
    - Patient registered
    - CT notified of arrival (ask unit clerk to call)
    - Ambulance triage
    - ED monitor applied
    - IV access/blood work if needed
    - Obtain tPA from Omnicell
    - Stretcher, monitor, IV pump, transport kit, and tPA from Omnicell is taken to CT department
- ☐ At CT:
    - ED stretcher ready outside of CT suite
    - Remove jewellery and dentures
    - 2nd IV insertion if needed
    - +/-tPA started & documented
    - Foley catheter inserted
    - Stay on portable monitor

FOR EVT PATIENTS ONLY!

SAMPLE

    - Triage note completed
- ☐ <u>If Patient Returning to ER:</u>
    - Usual care of patient +/- tPA
    - Return tPA to Omnicell
    - Change patient into gown
    - Baseline nursing assessment
    - Patient NPO until STAND

SAMPLE