GUELPH GENERAL HOSPITAL

Emergency Department
Code Stroke Record

MRN signature:_____ **Date & Time:** _____

Pre-Hospital Stroke Alert:

- Call "CODE STROKE arriving in _ minutes" overhead x 3
- ☐ Notify CT Tech about estimated time of arrival *(notify Xray Tech after hours)*
- ☐ Notify Emergency Physician time:_____hrs

Triage Nurse Acute Stroke Assessment

EMS Vitals Report	Pulse	BP	Resp Rate	O2 Sat	Temp	CBGM

1. Does the patient have any ONE of these neurological deficits? ☐ Unilateral arm/leg weakness or drift ☐ Slurred speech, or inappropriate words, or mute ☐ Unilateral facial droop	☐ Yes ☐ No
2. What is the EXACT TIME patient was LAST SEEN NORMAL? (24-hour clock – *hh:mm*):	_____:_____ Hour : Minute
3. Is the time of symptom onset LESS THAN 3.5 hours ago?	☐ Yes ☐ No
4. ED Physician Conduct Brief Initial Stroke Assessment: • Is this patient a POTENTIAL candidate for alteplase? • If YES → Call CODE STROKE → *document time*	☐ Yes ☐ No _____:_____ Hour : Minute

5.Orders BEFORE CT Scan

- ☐STAT registration of patient
- ☐Point of Care blood glucose (may use EMS result)_____mmol/L
- ☐Initiate 2 large bore IV's (greater or equal to 18 gauge & one antecubital)
  - IV # 1 **ANTECUBITAL** _____
  - IV# 2 _____
- ☐Call Criticall STAT → request TeleStroke Neurologist
- ☐Order-enter STAT CT Head Non-Contrast & page CT tech
- ☐CBC, diff, random glucose, electrolytes, urea, creatinine, plasma glucose, PTT/INR, Troponin I, CK, LFT's, Group and Screen, random lipid assessment, HgbA1C, ESR
- ☐If female and of child bearing age → add serum Beta-HCG

6.Orders AFTER CT Scan

- ☐ MRN document time CT Scan completed
- ☐ Transport patient back from CT Scanner on ED weighing stretcher, and weigh patient____Kg
- ☐ Keep head of bed at 30 degrees
- ☐ Set up Telestroke Ontario camera in patient's room
- ☐ ECG
- ☐ NPO
- ☐ Continuous cardiac monitor
- ☐ Initial Vital Signs documented, then repeat q15 minutes
- ☐ Complete Canadian Neurological Scale score
- ☐ Apply oxygen via nasal prong if oxygen saturation less than 92 %

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Will alteplase be administered to this patient? • *Document decision and time*	☐ Yes ☐ No _____:_____ Hour : Minute
Will this patient be transferred for endovascular therapy • *If yes, refer to stroke transfer orders 84-1004*	☐ Yes ☐ No _____:_____ Hour : Minute

7.CODE STROKE: Administration of alteplase

Obtain alteplase dose orders from ED Physician

Administer alteplase according to following instructions *(also refer to GGH Parenteral manual):*

- *RN to confirm doses and administer alteplase (IV therapy) via dedicated peripheral IV (use doses above):*
- *Reconstitute 100 mg alteplase vial with 100 mL sterile water provided. Follow directions. DO NOT SHAKE VIAL*
- *Remove "waste" from vial (listed above) and discard*
- *Give BOLUS alteplase IV dose (listed above) over 1 minute*
- *Follow immediately with infusion dose (listed above) over 1 hour.*
- *When the alteplase bottle is empty, remove the bottle. Attach a 100 mL NS bag to the line and infuse at same rate (to ensure residual alteplase in IV line is given to patient).*

Intravenous record

Date/ Time	Gauge	Site	Solution/product	TBA	Absorbed	Rate	Initial

Medication record

#	Date & Time	Medication	Dose	Route	Initial
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

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Vital Signs Record

8. **After alteplase infusion started, use following monitoring parameters:**
   - Vital signs q15 mins x 1 hour, then q30mins until transferred (can use manual OR automatic BP cuff)
   - Canadian neurological score q15 minutes x1h, then q30 minutes until transferred
   - Observe for Angioedema & document at 30 minutes, 45minutes and 60 minutes post infusion.

Date/Time	T	P	R	BP (Lt/Rt)	O2 sat	Angioedema Y/N/notes	Initial

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Nursing Record and Observations

Admitting MRP name: Dr.____________________________ **Admitted to:** ☐ **Step-down** ☐ **CCU**

- ☐ **Transfer orders available**
- ☐ **Transfer of accountability completed**

Patient Left ED: Date:___Time:__________MRN Signature: _________

CHART TO BE COPIED AND GIVEN TO REGISTRATION

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	Canadian neurological Scale	Pre-alteplase	15 min.	30 min.	45 min.	1 hour					
	Date: (mm/dd/yyyy) Time: (hh:mm)										
	PUPILS: Size and Reaction to Light (+ or -) R										
	L										
SECTION A MENTATION * If pt. is comatose/stuporous use Glascow Coma Scale	**Level of Consciousness Alert 3.0 Drowsy 1.5**										
	Orientation Oriented 1.0 Disoriented or N/A 0.0										
	Speech Normal 1.0 Expressive deficit 0.5 Receptive deficit 0.0										
	Motor Function:										
SECTION A1 MOTOR FUNCTION No Receptive Deficit	**Face Symmetrical 0.5 Asymmetrical 0.0**										
	Arm: Proximal None 1.5 Mild 1.0 Significant 0.5 Total 0.0										
	Arm: Distal None 1.5 Mild 1.0 Significant 0.5 Total 0.0										
	Leg: Proximal None 1.5 Mild 1.0 Significant 0.5 Total 0.0										
	Leg: Distal None 1.5 Mild 1.0 Significant 0.5 Total 0.0										
SECTION A2 MOTOR RESPONSE Receptive Deficit Present	**Motor Response**										
	Face: Symmetrical 0.5 Asymmetrical 0.0										
	Arms: Equal 1.5 Unequal 0.0										
	Legs: Equal 1.5 Unequal 0.0										
TOTAL SCORE	**A + A1 OR A + A2**										
Initials											

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Canadian Neurological Scale (CNS) instructions for use

- **Maximum score of 11.5**
- ***One* point decrease may indicate a significant change in neurological status**

Assess: Vital Signs and Pupils

Section A: MENTATION (LOC, Orientation, Speech)

Level of Consciousness:

Perform the CNS if patient is alert or drowsy. GCS if the patient is stuporous or comatose.

ORIENTATION:

Place (city or hospital), Time (month and year)

*Patient can speak, write, or gesture their responses.

SCORE: Patient is Oriented, score 1.0, if they correctly state both place and correct month and year. If dysarthric, speech must be intelligible. If patient cannot state both, Disoriented, score 0.0.

SPEECH:

RECEPTIVE: Ask patient the following separately (do not prompt by gesturing):

1. Close your eyes
2. "Does a stone sink in water?"
3. Point to the ceiling

SCORE: If patient is unable to do all three, this indicates a RECEPTIVE DEFICIT, score 0.0, and go to A2. If patient is able to answer all three, continue to assess EXPRESSIVE.

EXPRESSIVE:

1. Show patient 3 items separately (pen, watch, and key) and ask patient to name each object.
2. Ask patient what each object is used for while holding each up again, i.e. "What do you do with a pen?"

SCORE: If patient is able to state the name and use of all 3 objects, Normal Speech, score 1.0.

If patient is unable to state the name and use of all 3 objects, Expressive Deficit, score 0.5.

*If patient answers all questions correctly but speech is slurred and intelligible, score Normal Speech and record 'SL' along with the score.

Section A1: MOTOR FUNCTION

NO RECEPTIVE DEFICIT – Do not complete if patient has a Receptive Deficit

FACE: Ask patient to smile/grin, note weakness in mouth or nasal/labial folds.

SCORE: None/no weakness = 0.5 or Present/Weakness = 0.0. Test both limbs and always record the side with the WORST deficit and indicate side by entering R (Right) or L (Left).

SCORING FOR ARM AND LEG WEAKNESS: Only Score weakest side

None 1.5	No weakness present
Mild 1.0	Mild weakness present, full ROM, cannot withstand resistance
Significant 0.5	Moderate weakness, some movement, not full ROM
Total 0.0	Complete loss of movement; total weakness

SCORE:

Arm Proximal: Ask patient to lift arm 45-90 degrees. Apply resistance between shoulder and elbow.

Arm Distal: Ask patient to make a fist and flex wrist backwards, apply resistance between wrist and knuckles.

Leg Proximal: In supine position, ask patient to flex hip to 90 degrees, apply pressure to mid-thigh.

Leg Distal: Ask patient to dorsiflex foot, apply resistance to top of foot.

Section A2: MOTOR RESPONSE

RECEPTIVE DEFICIT PRESENT

FACE: Have patient mimic your smile. If unable, note facial expression while applying sternal pressure.

ARMS: Demonstrate or lift patient's arms to 90 degrees, score ability to maintain equal levels for > 5 seconds. If unable to maintain raised arms, apply nail bed pressure to assess reflex response.

LEGS: Life patient's hip to 90 degrees, score ability to maintain equal levels for > 5 seconds. If unable to maintain raised position, apply nail bed pressure to assess reflex response.