

Kingston General Hospital: Stroke EVT Pilot Study Data Flow Sheet 2016 (rev May 13 2016)

Name:

Recorder:

Chart Record Number:

Age:

Neurologist(s):

Interventional radiologist(s)

ED RN(s):

DI and IVR MRT(s):

IVR RN(s):

| Element: | Recordings: | Observations |
|--|------------------------------|--------------|
| Date: | | |
| Stroke Onset (hhmm): | | |
| Time in ambulance if transported by EMS: | | |
| Modified Rankin Scale prior to Stroke Onset: | | |
| Part A: From ER arrival to CT to IVR to K2ICU | | |
| ER Arrival Time ("Door Time", hhmm): | | |
| NIH Stroke Scale Score: | | |
| Time of Arrival at CT (hhmm): | | |
| Time of CT <u>First Slice</u> ("CT first slice Time", hhmm): | | |
| Time of CTA completion when the images are available to be reviewed on PACS ("CT completion Time", hhmm): | First images available | |
| | Full set of images available | |
| CT ASPECTS: | | |
| Clot Location: | | |
| Collateral Score (0 to 5): | | |
| Time that IVR was notified: | | |
| Time that Kidd 2 was notified of potential patient (Davies 4 then notified if thrombectomy case not needing D4 ICU bed): | | |
| Time of IV tPA bolus ("Needle Time", hhmm): | | |
| Door-Needle time (hhmm): | | |
| Time of Start of IV tPA infusion (hhmm): | | |
| Total dose of IV tPA calculated (mg): | | |
| Time that IVR is ready to receive patient (hhmm): | | |
| Time that patient arrives in IVR (hhmm): | | |

| | | |
|---|--|--|
| Anesthesia notified (Y/N)? | | |
| Time of Groin Puncture (hhmm): | | |
| CT to Groin Puncture time (hhmm): | | |
| Procedure aborted (Y/N)? | | |
| Time of First Reperfusion (hhmm): i.e. when TICI 2b or 3 is achieved | | |
| CT to First Reperfusion (hhmm): | | |
| Time of Completion of EVT (hhmm): | | |
| Reperfusion grade (TICI scale, TICI 2b or 3 is good): | | |
| Procedural sedation needed (Y/N)? | | |
| Anesthesia or Critical Care needed during procedure? | | |
| Blood pressure management in IVR: | | |
| Medications used in IVR, and dose: | | |
| Stroke Neurology Team present throughout procedure (Y/N)? | | |
| Number of pages or calls taken by Stroke Neurology Team during procedure: | | |
| Number of stent-retrievers used: | | |
| Number of passes done: | | |
| Carotid stent used: | | |
| Additional procedures or material used: | | |
| Sheath left in (Y/N)? (make note if angioseal used) | | |
| Time that K2ICU was notified: | | |
| Time of Leaving IVR (hhmm): | | |
| Time Between IVR Ready for Patient and Patient Leaving IVR (hhmm): | | |
| Causes of Delay in Leaving IVR: | | |
| Time of Arrival in K2ICU (hhmm): | | |
| Door-K2ICU Arrival Time (hhmm): | | |

| Part B: K2ICU Arrival to ASU: | |
|--|--|
| Date of arrival in K2ICU: | |
| Date of arrival in ASU: | |
| TIME of Initial Canadian Neurological Scale (CNS) performed in ICU | |
| Initial SCORE on Canadian Neurological Scale (CNS) in ICU | |
| Any changes in CNS over first 24 hours requiring intervention | |
| Any adverse reactions or interventions required – e.g. blood pressure management, angioedema, bleeding, seizures | |
| Total time spend under Critical Care (dd): | |
| Total time spend waiting for ASU bed (dd): | |
| NIHSS score on Day 1: | |
| Follow-up CT ASPECTS: | |
| Hemorrhagic transformation (Y/N)? | |
| Intracranial Hematoma size (cc): | |
| Groin puncture site complications: | |
| Highest sBP and dBP in K2ICU stay: | |
| Lowest sBP and dBP in K2ICU stay: | |
| Fever, aspiration, delirium or other stroke complications? | |
| Medication used in K2ICU stay: | |
| Part C: ASU Arrival to Hospital Discharge | |
| Complications in ASU: | |
| LOS on ASU: | |
| LOS in Hospital: | |
| Discharge destination: | |
| NIHSS on discharge: | |
| Transferred to Critical Care or Medicine during hospital stay (Y/N)? | |
| Debriefing done for ER, Neuroradiology and CT, Neurology, IVR, Critical Care and Anesthesia? | |

| Part D: Hospital Discharge to 90 days | |
|---|--|
| Readmission to hospital within 30 days? | |
| Recurrent stroke or TIA within 90 days? | |
| ED visits over 90 days – dates/times, all causes: | |
| Dates and LOS for each readmission: | |
| Where living now AND Where living at time of stroke | |
| Modified Rankin Scale score at 90 days: | |
| Total number of days living at home between Stroke Onset and 90 days: | |
| Died before 90 days? When? Cause? | |

FOLLOW UP/EVALUATION

From Administrative Data (CIHI NACRS, DAD)

- Pre-admit co-morbidities
- In-hospital complications- all
- In-hospital mortality (up to 30 days)
- Discharge disposition and if transferred, institution name
- ED visits over 90 days – dates/times, all causes
- Readmissions over 90 days (for all causes including stroke/TIA)
- Reasons for readmissions and ED visits up to 90 days
- Dates and LOS for each readmission up to 90 days

Cost Measures

Consider case costing (visit number and associated CR# costs linked with cost centre for equipment used)

- IVR Costs:
 - Staff resources
 - Equipment used
- Anesthesia costs if any?
- Hospital LOS – acute, ALC, total
(For further input from Lana Cassidy)

Debriefing Notes

- Was ESCAPE protocol followed?
- Review of timelines, process measures, outcomes to date
- What went well?
- What did not go well?
- Any critical incidents?
- What needs to change?- actions to be taken
- Plan for communication and follow up
- Include a report back to ED, IVR and ICU on the 90 day follow- up visit/outcomes of previous cases
- Other comments or input?