Stroke Awareness and Prevention

Physician and Advanced Practice Professional Education

September 2025

Physician and Allied Health Professional Stroke Education

Kaweah Health is a Primary Stroke Certified center through the Joint Commission since 2018

Physician and Allied Health Professional Stroke Education

This means that all stroke patients are evaluated and managed according to the current evidence and recommendations as outlined by the American Heart Association/American Stroke Association guidelines

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Most stroke patients are admitted at KH, but those requiring advanced endovascular or neurosurgical intervention are transferred to a tertiary care center

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On presentation to the Emergency Department….

Suspected stroke patients have a *Stroke Alert* called, which prioritizes them for physician evaluation, CT imaging, and neurology consultation

Admission criteria and destination is outlined on the next slide

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TIA/STROKE Guidelines

NURSING WORKLOAD	ICU	ICCU	OTHER UNIT
	• Ratio 1:1, 1:2 • **Continuous** observation and interventions more frequently than every 2 hours	• Ratio at most 1:3 • **Frequent** observation and intervention no more frequently than every 2 hours for limited time.	• Tele-Med/Surg Ratio 1:4 • **Routine** observation and intervention no more frequently than every 4 hours.
STROKE/TIA Policy References: 1) PC.19 Medication Administration 2) PC.180 Patient Placement Guidelines	• Cerebellar hemorrhage • CVA with Thrombolytics –ICU level of care suggested for 24 hours after Thrombolytic administration • CVA with Airway compromise • CVA with Hemodynamic Instability • CVA with Mod. Hemodynamic Instability requiring vasoactive medication titration – Preferred ICU • Hemorrhagic CVA with Hemodynamic Instability	• Hemorrhagic CVA - Hemodynamically stable and patent airway • Cerebellar Stroke - critically stable.	**OBSERVATION UNIT** (PREFERRED 2 SOUTH): • TIA patients **MED/SURG/TELE UNIT** (PREFERRED 4 SOUTH): • CVA patients

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To assist in achieving the best evidence-based care for stroke patients as well as being in compliance with Joint Commission standardized practices, admission PowerPlans have been developed.

These should be used for patients admitted for TIA, ischemic stroke, and hemorrhagic stroke

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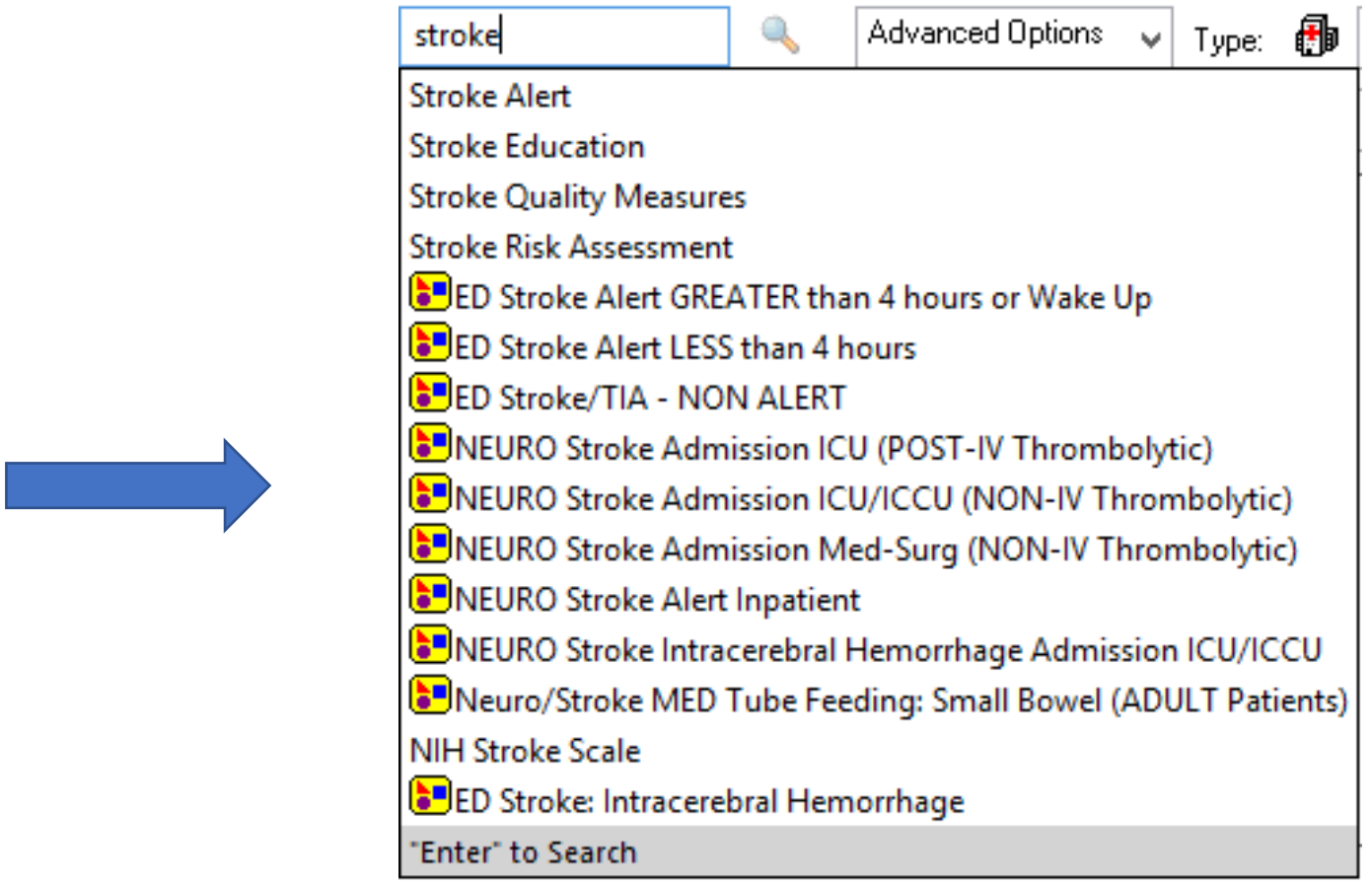
The Stroke PowerPlans can be found by typing in “stroke” in Cerner order entry



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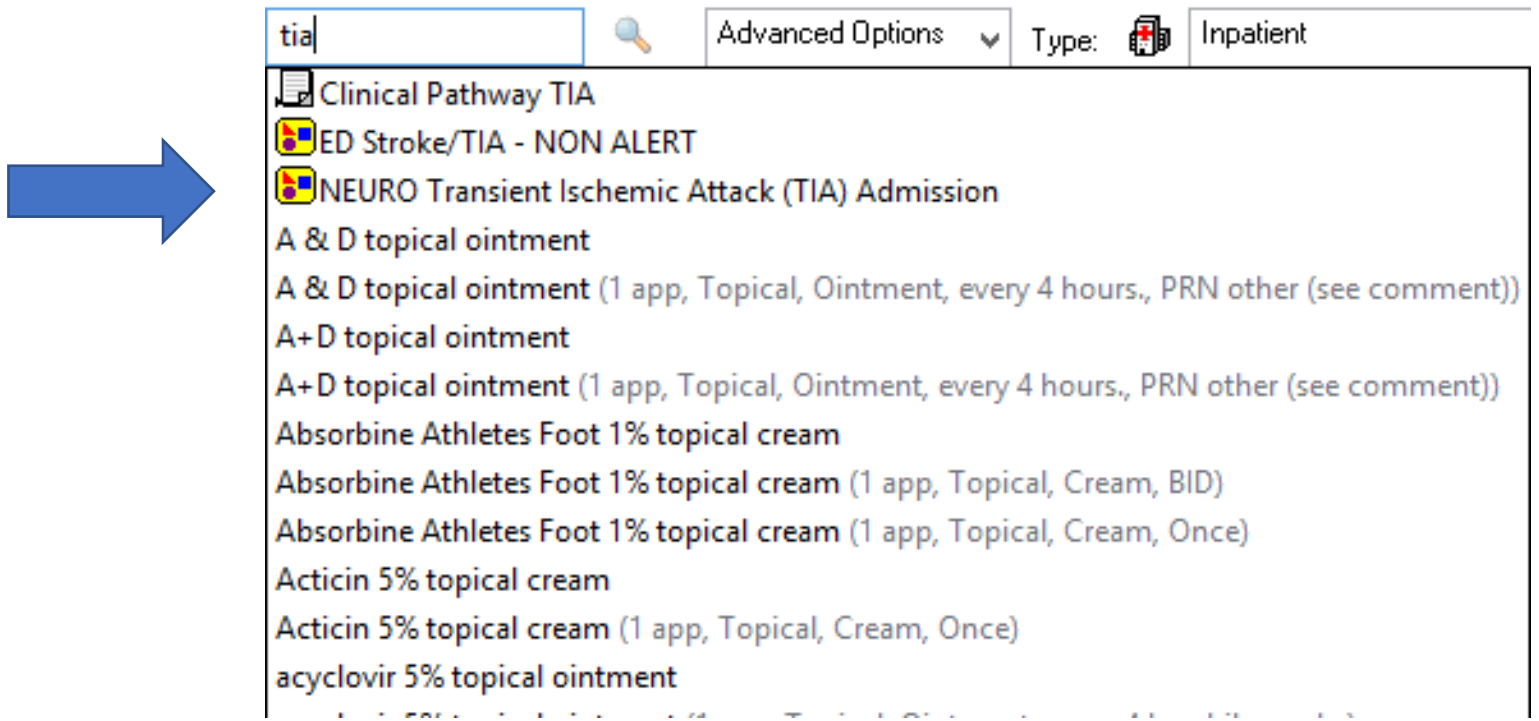
The TIA Observation PowerPlan can be found by typing “TIA” in Cerner order entry



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Our recent recertification survey from the Joint Education(March 2025) found opportunity for increased compliance in our use of order sets.

As an action plan, we have set a **benchmark of 92% compliance** of orderset use in the Emergency Department and on admission orders for all stroke and TIA patients

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Patient education is a required component of our service as a stroke center

This dotphrase allows you to incorporate patient education on cardiovascular risk factors into your documentation

Dot-phrase [..stroke_risk]

Patient Education on Cardiovascular Risk Factors
The following marked items were identified as risk factors for stroke for the patient.
Strategies to address these risk factors were discussed with the patient.
[_] Hypertension
[_] Hyperlipidemia
[_] Diabetes
[_] Physical Inactivity
[_] Overweight/Obesity
[_] Smoking
[_] Atrial Fibrillation

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Inpatient Stroke Alert process

- For patients who have acute onset of new neurologic symptoms, or an increase in NIHSS score of 3 or more, the rapid response team (RRT) is activated to evaluate the patient
- The RRT RN will perform a full NIHSS score, activate the stroke alert, and will notify the attending physician
- The patient's attending physician is expected to respond within 15 minutes of notification (in person is preferred)
- The attending physician will discuss care with the on-call neurologist as needed to determine need for further imaging (e.g. CTA of the head/neck) and treatment options such as IV thrombolytics or transfer for interventional treatment

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Inpatient Stroke Alert process - continued

- MD to MD communication should be accomplished within 20 minutes of the in-house stroke alert. The primary care physician will discuss treatment options with the on-call neurologist.
- Clear communication by the primary care physician with all responders on the treatment plan is essential (e.g., tenecteplase administration or transfer for large vessel occlusion).
- The RN may request the PCP come to the bedside for immediate evaluation (within 30 minutes)
- If IV thrombolytics are given as a result of an inpatient stroke alert the primary care physician will transfer the patient to the ICU
- If a new or expanding hemorrhage is found on CT, the attending physician will consult neurosurgery to assist in determining the treatment plan

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Inpatient Stroke Alert process

RRT RN - Stroke Alert Neurology Call

- Patient age
- Admitted for ... on hospital day #...
- Reason stroke alert called (new neurologic symptoms or worsening of previous symptoms)
- Last seen normal time
- Current NIHSS score (and what the new deficits are)
- Previous NIHSS score
- Past Medical History (especially important are cardiac and neurologic disorders, history of seizures, history of diabetes, recent surgery/arterial punctures)
- Current Medications – especially anticoagulants

If you have time to gather it

- Any abnormal findings on the patient's initial CT or CTA (if they were initially seen as a potential stroke patient)
- Family contact name and number (if the patient is unable to make their own medical decisions)

RRT RN - Duties

(see in-house stroke alert checklist for full list of duties)

- Call stroke alert if patient meets criteria (+BE FAST OR NIHSS ≥ 3 points)
- Primary RN to assist with LKW verification
- Place in-house stroke alert PowerPlan (attending physician)
- Obtain patient information using script
- Call primary care physician (PCP)
  - Prep patient for CT imaging at the same time
  - PCP/Neurologist will determine if CT and/or CTA is needed
- If the PCP does not respond within 15 minutes (preferably at bedside) contact the on-call neurologist for treatment plan.
- If the neurologist does not respond within 10 minutes; refer to AMiON schedule and contact the back-up neurologist
- Primary RN to contact attending physician with update
- RRT RN may request attending and/or neurologist to come to bedside if possible tenecteplase, new hemorrhage or large vessel occlusion

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Know the signs of stroke

FAST emergency treatment may reduce disability and save your life

How to Call for Help

BE FAST emergency treatment may reduce disability and save a life!!

911

If you are in the community - call 911.

9-911

If you are at work, but outside the acute hospital – call 9-911 and call for help

44

If you are in the acute care hospital – call 44 and a Rapid Response (RRT)

Stroke Program Leadership

Dr. Sean Oldroyd
Stroke Program Medical Director

Cheryl Smit, RN-BC
Stroke Program Manager

Kaweah Health
MORE THAN MEDICINE. LIFE.

The pursuit of healthiness