Clinton Regional Hospital	**Policy and Procedures** **Code Stroke Policy/Procedure**	NUMBER
	MANUAL: Internal and Hospital Team	EFFECTIVE DATE 06/05/2025
	SUBJECT: Stroke	REVISED 04/09/2026 REVIEWED

I. Policy Statement

This policy aims to provide a standardized approach to the identification, assessment, treatment, and rehabilitation of stroke patients, ensuring the highest quality of care and patient safety.

II. Scope

This policy applies to all healthcare personnel involved in the care of patients presented with stroke symptoms in the hospital.

III. Definitions

- Stroke: A medical condition where the blood supply to the brain is interrupted or reduced.
- Ischemic Stroke: Caused by a blockage in a blood vessel supplying the brain.
- Hemorrhagic Stroke: Caused by bleeding in or around the brain.
- Transient Ischemic Attack (TIA): A temporary period of symptoms similar to those of a stroke.

IV. Responsibilities

- All clinical staff must be trained to recognize stroke symptoms and activate stroke protocols immediately.
- Specific roles defined for emergency department staff, radiologists, nursing staff, lab and respiratory services.

V. Protocols

- Signs and Symptoms: Use the FAST method for recognition (Face drooping, Arm weakness, Speech difficulties, Time to call emergency services).
- Activation of Code Stroke Alert: Immediate alerting of the stroke team upon recognition of symptoms.
    - If patient is a walk in with sudden change in neurological status and positive FAST use STROKE button on facility phones in Emergency Room to notify lab, radiology,

and provider of code stroke by tapping STROKE button and stating, "Code Stroke" two times.

- If patient is brought in by ambulance with an arrival time greater than 5 minutes from time Emergency Room (ER) staff is notified then ER staff may use STROKE button OR call departments individually for notification of incoming critical patient.

- Initial Evaluation: Conduct a rapid assessment using the NIH Stroke Scale upon patient arrival.
- Imaging and Diagnostic Procedures
  - Orders for Stroke to be placed by ER staff or Provider within 10 minutes of patient arrival.
    - See CRH Stroke Order Set for applicable orders.
    - Order for CT scan **MUST** have STROKE in the comment section.
  - If patient is brought in by ambulance with positive stroke symptoms, ambulance staff is to take pt directly to CT upon arrival.
  - If patient is a walk in or begins to have stroke symptoms while in ER, patient is to be taken to radiology immediately for emergent CT scan.
- Treatment Protocols for Ischemic Stroke and Hemorrhagic Stroke
- Post-Acute Management
- Education and Communication with patients and families on strokes.

I. Rapid Recognition and Activation:

- Public education on stroke symptoms (like FAST) and the importance of calling emergency services is vital.
- Emergency Medical Services (EMS) should notify the ED and activate the stroke alert protocol before arrival.
- Upon arrival, within 10 minutes, ED staff should:
    - Assess for stroke symptoms, especially with recent onset, and inform the ED provider.
    - Activate a "Stroke Alert" or "Code Stroke" if stroke is suspected.
    - Perform a rapid assessment of ABCs and vital signs.
    - Check point-of-care glucose and treat hypoglycemia.
    - Determine and record the last known normal time.
    - Conduct a rapid neurological exam using a validated scale (e.g., NIHSS).
    - Obtain IV access and order an emergent non-contrast CT to rule out hemorrhage.
    - Order baseline blood work (CBC, INR, aPTT, creatinine) and a 12-lead EKG.
- Within 15 minutes of arrival, the stroke team should be notified and respond to review history, timeline, and perform a detailed neurological exam.

II. Diagnostic Imaging (within 25-45 minutes of arrival):

- Perform a non-contrast head CT to rule out hemorrhage and stroke mimics.
- Perform CT angiography (CTA) to assess for large vessel occlusion and determine treatment eligibility.
- Within 45 minutes of arrival, a physician with expertise in neuroimaging should interpret the scans. If hemorrhage is present, consult neurology or neurosurgery. If not, consider fibrinolytic therapy eligibility.

III. Treatment Decisions and Administration (Door-to-Needle Time ≤ 60 minutes):

- For fibrinolytic therapy (IV alteplase), administer as soon as possible, ideally within 4.5 hours of symptom onset. Screen for contraindications and ensure blood pressure is

≤185/110 mm Hg. Administer according to protocol and monitor blood pressure closely. Keep the patient NPO

- Consider mechanical thrombectomy (EVT) for eligible patients with large vessel occlusion up to 24 hours after symptom onset, using validated tools like ASPECTS. If your facility doesn't perform EVT, have protocols for rapid transfer to a comprehensive stroke center.
- Administer aspirin to patients with ischemic stroke not receiving rtPA.
- IV. Ongoing Care and Monitoring:
- Admit patients to a stroke unit for close monitoring, including frequent neurological assessments and vital signs.
- Optimize physiological parameters such as blood pressure, glucose, temperature, and fluids.
- Complete a swallowing screen as soon as possible, ideally within 24 hours.
- Implement measures to prevent complications like aspiration pneumonia, DVT, and UTIs.
- Provide ongoing stroke education for staff.
- V. Virtual Acute Stroke Care (Telestroke): (If available)
- Utilize telestroke networks for access to stroke expertise when needed.
- Ensure real-time, two-way audiovisual communication and access to images during virtual consultations.
- Have standardized protocols for virtual consultations and patient transfer.