PROTOCOL FOR: **Cerebral Vascular Accident (CVA), Suspected**

POLICY: The patient presenting with signs and symptoms of acute stroke will be promptly assessed and evaluated by the Emergency Department physician/APRN/PA.

DESIRED PATIENT OUTCOMES: The patient will receive appropriate assessment, evaluation and treatment.

CLINICAL ASSESSMENT AND CARE:

1. Assess airway, breathing, circulation, time of symptom onset and obtain pre-hospital scores if available from EMS (i.e., Cincinnati or Los Angeles Prehospital Stroke Score). Assign Emergency Acuity (red).

2. Treat life-threatening occurrences immediately (i.e., loss of airway, respiratory distress, cardiac compromise or arrhythmia).

3. Perform secondary assessment of neurological deficits and possible comorbidities.

4. Initiate oxygen at 2-4L nasal cannula and titrate to maintain oxygen saturation > 92%.

5. Place on cardiac monitor, NIBP, pulse oximeter and obtain/document full set of vital signs, including pain scale.

6. Obtain fingerstick glucose, even if already obtained and reported by EMS.

7. Obtain IV access and blood work (i.e., CBC, PT/PTT, CK, CK/MB, troponin, type & screen, chem 10) as per physician/APRN/PA order. Obtain ABG if hypoxia suspected.

8. Assess level of consciousness, motor deficit, sensory deficit, speech deficit and visual deficit.

9. Prepare for non-contrast head CT or MRI scan per physician/APRN/PA order and prepare for consultation with the on-call Neurology Attending Physician.

10. Obtain EKG per physician/APRN/PA order. Obtain CXR if lung diseases suspected.

11. Perform re-assessments, including neuro checks, with vital signs as indicated (i.e., every 15 minutes with active medication titration), minimally every two hours.

12. Based on CT/MRI results:

    a. If acute ischemic stroke suspected, prepare for possible thrombolytic therapy per ED attending physician order. The ordering physician must complete a thorough review of inclusion/exclusion criteria as outlined by the American Heart Association and further neurologic assessment/evaluation (i.e., the National Institute of Health Stroke Scale (NIHSS)). The ED

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physician must also consult the Neurology attending physician prior to administering t-PA. Refer to the protocol for Alteplase (t-PA): Administration for Acute Ischemic Stroke.

b. If hemorrhagic stroke, prepare for reversal of anticoagulant, treatment of hypertension and/or surgical intervention.

13. Administer other meds as ordered by physician/APRN/PA (i.e., labetolol, nitroglycerin, nitroprusside and aspirin).

14. Assist with other diagnostic procedures per physician/APRN/PA order (i.e., Doppler, lumbar puncture). Fibrinolytic therapy is contraindicated if a lumbar puncture is performed.

15. Prepare for transfer to ICU, Cardiac Step-Down Unit or Med-Surg Unit as deemed appropriate. (If patient receives t-PA, the patient must be admitted to ICT due to the frequency of required assessment and monitoring.)

16. Obtain vital signs/pain reassessment upon discharge/transfer from the ED.

PATIENT AND FAMILY TEACHING:

1. Explain all procedures to patient/family.
2. Keep patient/family informed of plan of care.

REPORTABLE CONDITIONS:

1. Signs of elevated ICP or ICH (i.e., worsening headache, nausea, vomiting, decreased level of consciousness).
2. BP > 185/110 for 3 consecutive readings in ½ hour.
3. Bleeding
4. Allergic reaction

DOCUMENTATION: Document all vital signs, assessments, medications, interventions and response to interventions on ED record.

ASSOCIATED PROTOCOL: ED Unit Practice Manual:
Altepase (t-PA): Administration for Acute Ischemic Stroke

APPROVAL: Emergency Department Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 11/04

REVISION DATES: 3/06, 12/07, 2/09

REVIEW DATES: 10/09