**Code Stroke Checklist - INPATIENT**

**Primary Nurse**
- Identify stroke symptoms → think “FAST”
- Identify exact time patient was “last seen” normal (LSN)
- Engage Code Stroke Nurse and MRP STAT (x5555 “Suspected Stroke + Location”)
- Support Code Stroke Nurse as directed; accompany patient

**MRP**
- Case awareness
- Support/update family if possible

**Code Stroke Nurse (supported by Primary Nurse)**
- Respond to ward; bring Code Stroke Binder (and portable cardiac monitor – EGH only)
- Assess patient → think “FAST”
- Activate Code Stroke (x 5555 “Code Stroke + Location”)
- Connect patient to vitals monitor → Baseline Vital Signs and Neuro Vitals
- Start 2 large bore IVs (18 gauge preferred)
- Assess Capillary Blood Glucose
- Draw blood work → CBC, APTT, PT/INR, Thrombin time, Electrolytes, Creatinine, Glucose, Urea, CK, Troponin, if female<60yrs of age, serum BHCG, type, screen and freeze
- Baseline modified NIHSS STAT to assess stroke symptoms
- STAT 12 lead ECG *
- Monitor oxygen, O2 saturation ≥92%

**Code Stroke Physician (GIM)**
- Initiate Evaluation of Suspected Acute Stroke Order Set
- Complete NIHSS
- Confirm need to access Telestroke (direct Code Stroke Nurse)
**Code Stroke Nurse**

- Implement Evaluation of Suspected Acute Stroke Order Set once directed/ordered by Code Stroke Physician (GIM)
- Ensure immediate transfer to CT with appropriate resources and equipment; accompany patient with Primary Nurse
- Engage Code Stroke Physician to confirm need to connect with Telestroke. If so, call CritiCall (1-800-668-4357) to request Telestroke consult and provide phone extension/number for call-back (Telestroke Neurologist → Code Stroke Physician phone call)
- Ensure the OTN system # is known (located on the cart)
- Direct porter to bring in OTN Cart into DI Bay (EGH only)
- Connect OTN Cart to the OTN port within the DI Bay and establish connection/power
- Ensure family member updated/notified

**Code Stroke Physician (GIM)**

- Engage with Telestroke Neurologist via phone (Neurologist will call Code Stroke Physician to briefly discuss case over the phone)
- Engage with Telestroke Neurologist via virtual care (Neurologist will automatically connect to Osler via OTN Cart post call)
- Complete tPA Order Set, if confirmed
- Complete the Billing Information for TeleStroke Consultant and fax accordingly (clerk to assist)
- Code Stroke Nurse
  - tPA confirmed – Call x 5555 to confirm treatment (“tPA Code Stroke Confirmed”)
- Call Critical Care Resource Nurse/Team Lead to access tPA drug (and IV pump – EGH only; and portable cardiac monitor – BCH only)
- Continuous monitoring of patient vital signs
- Critical Care Resource Nurse/Team Lead brings tPA and portable cardiac monitoring to DI (and IV pump – EGH only)
- Administer drug to patient **

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**Canadian Stroke Best Practice Guidelines:**

- Triage to CT performed: ≤25 min

- **Target door-to-needle for tPA:**
  - Median time of 30min, with 90th percentile being within 60min
Primary Nurse ➔ Code Stroke Nurse transfer of accountability

* Can be deferred until after imaging is completed so as not to delay assessment for treatment.

** If a Critical Care bed is available, administer tPA and transfer. If a bed is not available, continue to monitor patient with appropriate equipment within DI. If patient is a candidate for endovascular therapy as per Telestroke Consultant, “Drip & Ship” (TeleStroke Neurologist initiates CritiCall – Usual Neurointerventional Pathway