

F.F. Thompson Hospital STROKE TEAM

Meeting Minutes

April 3, 2014

Present:

Ragan Stevens, Jessica Schojan, Sarah Clayson, Bruce Gage, Sarah Gallagher, Paul Sandroni, Kiera Kuhn, Josh Kulp, Carlos Ortiz, Cheryl Quigley, Kim Ricigliano, Hazel Robertshaw, Antonio Russo, Justin Rymanowski

Next meeting:

May 1, 2014 – Board Room – 3pm

ITEM	DISCUSSION	ACTION
<p>Measures – February</p>	<p>IV rt-PA treat by 3 hrs – 100%</p> <p>Early Antithrombotics – 80% <i>(1) pt that was excluded from the measure – an ischemic patient that presented with stroke-like symptoms but was found to have cancer brain mets as well. Contraindication to antithrombotic must be explicitly documented by provider.</i></p> <p>VTE Prophylaxis – 85.7% <i>(1) pt that was excluded from the measure – an ischemic patient that had SCDs ordered but not charted. Concurrent review was done on this patient with the request for SCDs to be charted. The patient was an ED hold patient and it is not common practice to place SCDs on pts while in the ED.</i></p> <p>Antithrombotics at discharge – 83.3% <i>(1) pt that was excluded from the measure – an ischemic patient that presented with stroke-like symptoms but was found to have cancer brain mets as well. Contraindication to antithrombotic must be explicitly documented by provider.</i></p> <p>Anticoag for Afib/flutter – n/a</p> <p>Smoking Cessation – 100%</p> <p>Statin prescribed at discharge – 100%</p> <p>Dysphagia Screening – 75% <i>(3) pts were excluded from the measure. (1) was a pt that was a direct admit from his MD's office with confusion. MD was doubtful of stroke and so stroke workup was not initiated and so no dysphagia screening was completed. However, MRI showed hemorrhage. (1) was a hemorrhagic patient in the ED that received a dysphagia screening AFTER already having been given PO. (1) was a an ischemic patient that arrived with stroke-like symptoms but a dysphagia screen was not done in the ED.</i></p> <p>Stroke Education – 80% <i>(1) pt was excluded from the measure – ischemic stroke patient with brain mets that was discharged from 3W without education.</i></p> <p>Rehabilitation considered – 100%</p>	<p>Sarah G to send feedback letter to particular provider.</p> <p>Josh to inquire about availability of SCD machines for the Emergency Department.</p> <p>Sarah G to send feedback letter to particular provider.</p> <p>Sarah G to send feedback letter to the particular RNs.</p> <p>Sarah G to mail education to the patients that were missed.</p>

	<p>NIHSS Reported – 94.1% <i>(1) pt was excluded from the measure – a hemorrhagic stroke pt that was a direct admit from his MD office with confusion.</i></p> <p>NIHSS at Discharge – 90% <i>(1) pt was excluded from the measure – an ischemic pt with brain mets that did not have any NIHSS done at time of discharge from 3W.</i></p> <p>Modified Rankin Scale at Discharge – 100%</p> <p>Door-to-MD Assessment < 10 min – 83.4% <i>(1) Pt was seen later than 10 minutes after arrival – pt was seen within 12 minutes of arrival.</i></p> <p>Door-to-Stroke Team < 15 min – 100%</p> <p>Door-to-Brain Image Complete < 25 min – 66.7% Door-to-Brain Image Read < 45 min – 66.7% <i>(2) pts did not have a CT completed within 25 minutes or read within 45 minutes; both were strokes that occurred while the patients were inpatient and no code 15 was initiated.</i></p> <p>Labwork Resulted < 45 minutes – 68.4% <i>(6) pts had stroke panel bloodwork that took greater than 45 minutes to complete; (2) were related to Lab-related delays and (4) were ED-related delays.</i> Contrary to the message/intervention that has been encouraged in the past few months, Bruce informed the group that there is no longer enough staffing present anymore to guarantee that a lab tech will respond to code 15s. The group identified that there remains the need for a staff member dedicated to respond to all code 15s who ensures that the protocol is being timely placed (this is done by the charge RN for code 15s in the ED) and that labs are being delivered timely. There will still remain incidences (difficult access, critical interventions, etc) where labwork will not be timely; however, documentation of those reasons is encouraged. Bruce also shared his concern that there are particular lab orders for the inpatient code 15s that could be causing delays (i.e HCG, lipid panel).</p>	<p>Sarah G to send feedback letter to particular RN.</p> <p>Sarah G to share patient information with 3W charge nurses and Hospitalist for follow-up.</p> <p>Hazel to look into tech staffing and ensuring one will be available on all shifts to respond to inpatient code 15s.</p> <p>Sarah Clayson to work with Wendy Schultze and ensure that the inpatient code 15 panel and the ED code 15 panel are identical; particularly the lipid panel since the lipid panel should only be part of the stroke admission order set and not code 15 order set.</p>
<p>2013 Stroke Educational Requirements</p>	<p>Staff members that were non-compliant with their stroke education and NIHSS certification as of 12/31/13 have now completed all requirements.</p>	<p>Completed; no further action.</p>
<p>Rehab dysphagia in-service</p>	<p>Kelly Newton and Kim Riciigliano to coordinate an in-service with ED RNs on dysphagia screening. Kim has proposed some changes to the current paper dysphagia screening form and so the in-service is postponed until the screening form is agreed upon and finalized. Sarah C requesting an in-service for ICU as well. See section below for additional information.</p>	<p>Deferred at this time until dysphagia screening form discussion is finalized.</p>

<p>Updating Dysphagia Screening Forms</p>	<p>Kim share a new proposed Dysphagia Screening form with the group. She has received some feedback from nursing and welcomes additional feedback.</p> <p>Sarah G shared that the current paper Dysphagia Screening form is rarely utilized; rather, it is included in the stroke packet simply as a reminder for staff to complete a screening. Staff typically documents the screening and results in t-system (for ED patients) or McKesson (for inpatients).</p> <p>Sarah C and Jessica and Ragan shared that the Red Stroke Packets are not consistently maintained in the ICU and 3W and there remains confusion on what needs to be completed.</p> <p>Sarah G shared the discussion from last year about the purpose of the Red Stroke Packets; that they are provided as an instant resource to reference for patients that have a code 15 initiated. Documentation is not required on any of the paperwork; documentation in t-system and McKesson remains appropriate and encouraged.</p>	<p>Kim to update the new Dysphagia screening form with any feedback and will share at the next meeting.</p> <p>Sarah G to share the Access forms that are utilized in the ED Red Stroke Folders with Sarah C, Jessica, and Ragan for updating and maintaining the ICU and 3W Red Stroke Packets.</p>
<p>Follow-up on Dysphagia Screening / Evaluation Orders</p>	<p>Kim shared in the March meeting that she has experience with patients that have failed the nursing bedside swallow screen and therefore require a formal swallow evaluation by Speech, yet Speech is not notified and an order is not placed until someone eventually calls to inquire. It was discussed and clarified that nursing needs to be alerting the MDs to place orders for the formal speech evaluations when a patient fails the screening.</p>	<p>Deferred; follow-up not addressed at this meeting due to lack of time.</p>
<p>New hire stroke educational timeframe</p>	<p>It was discussed in the March meeting that NYS requires new hires to complete the 8 hours of stroke-related CME requirements within 60 days of hire.</p> <p>Sarah G met with Adrian and the 8 hours (including NIHSS certification) was added to the NAB outline and intranet for stroke unit RNs.</p>	<p>Sarah G to discuss specifics with the NYS rep at the next regional meeting (2/4).</p> <p>Sarah G to share MD new hire information with Heidi and Credentialing after talking with NYS.</p>
<p>Grand Rounds - 3/20/14</p>	<p>Dr. Rymanowski presented a Grand Rounds on the Management of Stroke in Younger Patients. It is now available on the intranet for those who were unable to attend.</p>	
<p>STAR Regional Stroke Management Symposium</p>	<p>There was a good turnout of FFTH RNs and MDs at the Regional Stroke Conference. One of the key takeaways was the room for improvement in FFTH's administration of TPA. Community hospitals are increasingly administering TPA; around 16% of ischemic patients. FFTH's rate for 2013 was 4.8%. While a large percentage of documented reason for no-TPA is due to a delay in the patient's arrival, there is also a moderate percentage related to "patient refusal." Therefore there could be opportunity of the Provider to better educate patients and families on the benefits of TPA.</p>	<p>? Education/Grand Rounds for Providers on benefits of TPA and better informing patients and families.</p>

<p>TPA policies, procedures</p>	<p>There has been confusion shared by nursing on the appropriate care required of patients s/p TPA administration (frequency of vital signs, neuro checks, NIHSS, etc). It was identified that there is not a great resource in place for nursing to reference promptly and universally. Sarah G included SMH's policy in the pre-meeting material for review and discussion.</p>	<p>Deferred; not addressed at this meeting due to lack of time. Team members to review and discuss at next meeting.</p>
<p>AHA Walk</p>	<p>4/12/14: Antonio is team leader for an FFTH group in the American Heart Association Walk. It is a 3.5 mile non-competitive walk along the Genesee River that starts at 10am on 4/12/14. No fee but fundraising is encouraged. It's not too late to join! http://heartwalk.kintera.org/rochesterny/ffthompsonhospitalbravehearts</p>	
<p>Staff Education</p>	<p>4/2, 4/3: Brain Injury – Stroke, Alzheimer's, & Head Trauma – Institute for Natural Resources 4/30/14: Grand Rounds for Nursing at FFTH – Stroke & Stroke Management – presented by URMC Stroke Coordinator. 3:30pm – 5:00pm. 5/29/14: 6th Annual NYS Stroke Conference – “New Challenges, New Opportunities Providing Outstanding Stroke Care in New York” – satellite location @ Hyatt Regency Rochester 6/5/14: Grand Rounds – Treating Hemorrhagic Stroke – Dr. Jahromi 10/23-10/24/14: The NorthEast Cerebrovascular Consortium 9th Annual Summit – Newport, RI</p>	