# KHSC-KGH Roles and Responsibilities Chart: Stroke Activation and Administration of IV Thrombolysis Endovascular Thrombectomy (EVT), or IV Thrombolysis+EVT

Dec 2003- updated April 3, 2024

<u>Function</u>	<u>Components</u>	Responsible Person
Communication re:	Pre-hospital pre-notification: Communicate with Regional Stroke	Paramedic
activation of Acute	Center ED. Upon scene departure, advise KGH that Stroke	
Stroke Protocol	Protocol is en route and estimated time of arrival	
	Additional updates to ED while en route to include establishment	
	of IVs or if patient becomes unstable	
	Call or delegate a KGH staff member to call Switchboard to alert	ED Charge Nurse
	Stroke Team: Stroke Protocol - XX minutes out	
	Initiate Stroke Protocol call	Switchboard
	Call KHSC-KGH staff listed in Appendix A	
	Ensure that all members on the Stroke Team are aware that	
	patient is on the way to the ED, and estimated time of arrival	
Communication re:	Page the Neurologist on Call for Stroke and the EVT Interventional	Switchboard
External Calls	Radiologist on Call (see Appendix B)	
Requesting EVT Stroke	If EVT is possible, contact Switchboard to initiate Stroke Protocol	Attending Neurologist
Team (e.g., from	If patient is unstable/intubated, also contact Kidd 2 ICU Intensivist	
Telestroke, CritiCall,	and Kidd 2 ICU Charge Nurse and ED Charge Nurse	
BGH-QHC)	<ul> <li>RT will be notified if patient is intubated by ICU team</li> </ul>	
Patient Registration	Register patient as soon as patient arrives in ED	ED Registration Clerk
Initial ED evaluation	Ambulance triage in ED	Triage-trained Nurse
including medical	If patient walks into ED, perform rapid triage with recognition of	
screening by ED	stroke symptoms	
physician or Neurologist	Ask ED Registration Clerk to register patient if not already done	ED Charge Nurse
	Notify CT of patient's arrival in ED	ED Unit Clerk
	<ul> <li>ED physician or Neurologist ensures that KGH staff</li> </ul>	
	member has notified CT of patient's arrival in ED	
	Upon patient arrival at central desk near Section A:	
	<ul> <li>Paramedic reports last seen well, symptoms, medical</li> </ul>	Paramedic
	conditions and medications if available, vital signs and	A., 1: A. 1
	glucometer reading	Attending Neurologist
	<ul> <li>ED physician or Neurologist does immediate medical</li> </ul>	or ED Physician-first to arrive
	screen to ascertain if patient is potential stroke patient	
Stroke Call cancellation	After arrival in the ED and ED physician or Neurologist has done	ED Charge Nurse
<u>if needed</u>	initial screen, if stroke activation is to be cancelled, notify or	
	delegate a KGH staff member to call Switchboard	
	Switchboard repeats calls to those listed in Appendix A and notes     "Graphs Brothers I am salls to"	Switchhoord
CT Decelines	"Stroke Protocol cancelled"	Switchboard
CT Readiness	Ensure that patient is "next on scan", and that CT scan is ready for     strate patient within 10 minutes of arrival to ED.	CT Technologist
Department of planning	stroke patient within 10 minutes of arrival to ED	Attanding Navaslasist
Repatriation planning	If Attending Physician suspects that patient may not be an IV     thrombolysis or EVT condidate, and will susplify for constriction.	Attending Neurologist
	thrombolysis or EVT candidate, and will qualify for repatriation	or ED Physician
	back to a bypassed community hospital ED, Dispatch will be	
	immediately contacted to request that the EMS crew be held up	
	to regulated timeframe, while decision is made as to IV	

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	thrombolysis +/-EVT candidacy, medical stability and medical diagnosis	
Medical assessment and	Initial assessment re: candidacy for IV thrombolysis with TNK or	Attending Neurologist
clinical decision making	rt-PA administration and/or EVT	Neurology House staff
	Completion of NIH Stroke Scale (included in the Stroke	under supervision of
	Assessment form found in Stroke Protocol package)	Attending Neurologist
Preparation of patient	Print blood labels	ED Nurse
before CT Scan	2 peripheral IVs - (1 IV with 18 Gauge needle in Rt. ACF is	
	preferred- if unable, use 20 Gauge; must be above the hand)	
	Bloodwork sent to lab using Acute Stroke Protocol package yellow	
	labeled blood tubes. Attending Physician directs Nurse to draw	
	bloodwork before or after CT. Waiting for bloodwork results is	
	not mandatory to make decision for IV thrombolysis +/-EVT	
<u>Lab Blood Work</u>	Lab processes bloodwork STAT and informs ED of results ASAP	Lab
Patient Transport to CT	Patient to remain on EMS stretcher until CT	ED Nurse
<u>Suite</u>	<ul> <li>Follow patient to CT suite with ED stretcher, monitor, pump,</li> </ul>	
	transport kit, and TNK or rt-PA from Omnicell	
	Transport patient to CT suite	Stroke Team
	Prior to CT scan, switch paramedic's monitor to ED monitor in CT	ED Nurse
	suite, check leads are moved away from center chest area	
	Ensure jewelry, dentures, and hearing aids are removed	
	Care for patient in CT Suite	Paramedic
C	Before Paramedics leaves KGH, report is given to ED Nurse	
Consent processes	Patent and family education is ongoing to prepare for consent      National appropriate in the interest for CTA if the in	Attending Neurologist
Consent for CT+/-CTA	<ul> <li>Verbal consent is obtained for IV contrast for CTA if this is to be used, and is documented in chart. If verbal consent cannot be</li> </ul>	CT Technologist
	obtained, emergency consent procedures are followed and	
	documented	
Medical Management &	Neurologist views CT scan +/-multiphase CTA and/or RAPID	Attending Neurologist
Decision Making	perfusion imaging with Neuroradiology	
	<ul> <li>Inclusion/Exclusion Criteria for TNK/rt-PA is used to determine</li> </ul>	
	thrombolytic therapy candidacy	
	Neurologist will use ESCAPE trial criteria and KGH Stroke EVT	
	Checklist to determine candidacy for EVT	
	If patient is candidate for administration of IV thrombolysis	
	and/or EVT, then patient will be transferred to Neurology Service	
	Medical management and clinical decision-making surrounding	
	initial and any additional radiological imaging performed (i.e., CT	
	Perfusion, MRI, MRA, Angiography). Interpretation of imaging.	
	Decisions re indications for pursuing additional diagnostic imaging. This is done keeping "time is brain" in mind	Attending Neurologist
	Accountability regarding clinical interpretation of diagnostic	and Interventional
	imaging and decision regarding treatment choice re:	Radiologist (when
	administration of IV TNK or rt-PA, and/or EVT	appropriate)
Communication re IV	If the patient is a candidate for IV Thrombolysis with Tenecteplase	
thrombolysis +/-EVT &	(TNK) or Alteplase (rt-PA):	Attending Neurologist
Bed Planning	<ul> <li>Notify D4ICU Charge Nurse</li> </ul>	ED Charge Nurse
	• If the patient is a candidate for EVT +/-IV thrombolysis:	
	<ul> <li>Notify Interventional Radiologist</li> </ul>	Attending Neurologist
	<ul> <li>Notify IR Technologist and IR Charge Nurse</li> </ul>	Interventional
		Radiologist

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	<ul> <li>After hours: Call back EVT team via Switchboard</li> </ul>	Interventional
	see Appendix B	Radiologist
	<ul> <li>Notify D4ICU or K2ICU(+ Intensivist)</li> </ul>	Attending Neurologist
	<ul> <li>If after hours and patient returning to ED to await IVR</li> </ul>	ED Nurse
	EVT team on call back, notify ED Charge Nurse	
	<ul> <li>Notify Operations Manager to locate or confirm critical</li> </ul>	D4ICU Charge Nurse/IR
	care bed in D4ICU or K2ICU & help with nurse staffing	Charge Nurse
IR suite triaging	In cases of more than one patient requiring emergent IR	Daily Operations Team
	procedures in IR suite, clinical decision & plan regarding most	for IR Suite with
	appropriate triage care must be executed in consultation with all	Attending Neurologist
	Attending Physicians responsible for care of all patients requiring	
	emergent IR procedures. Triage follows the principle that EVT/IA	
	rt-PA in appropriate stroke patients is an Emergency	
For patients who are not	If patient's clinical situation is not appropriate for administration of IV	
candidates for IV	thrombolysis +/-EVT, then patient may:	Attending
thrombolysis	A) be transferred to neurosurgery	Neurosurgery
administration +/-EVT:	B) be admitted via neurology to KGH Acute Stroke Unit – using order	Attending Neurologist
admission or	sets for those <b>not</b> receiving IV thrombolysis	
repatriation from ED	C) remain under care of ED physician or attending neurologist while	Attending Physician
	arrangements are made for patient to be repatriated back to local	(ED or neurologist)
	bypassed ED	
	In the case of C) ED to ED repatriation	
	<ul> <li>Dispatch must be immediately notified regarding the</li> </ul>	
	repatriation transport needs of the patient	
	<ul> <li>Criteria for repatriation from KGH ED to bypassed ED site:</li> </ul>	
	Established medical diagnosis	
	<ul> <li>Patient no longer needs tertiary care</li> </ul>	
	<ul> <li>Investigations that are NOT available at local facility</li> </ul>	
	are complete	
	Communication has occurred with	
	patient/family/substitute decision-maker	
	Reminder: D4ICU Charge Nurse or K2ICU Charge Nurse and	
	Operations (Ops) Manager should be notified if a critical care bed	ED Charge Nurse
	is not needed for the patient	25 charge rearse
Obtain consent for	NOTE: this process begins PRIOR to CT to prepare for timely decision	Attending Neurologist
IV thrombolysis	post CT.	Acceliating Neurologist
IN CHICHINOIDS	Patient or substitute decision-maker is provided appropriate and	
	specific information regarding risks and benefits of the planned	
	procedure, and sufficient time is given to patient/family to give	
	informed consent	
	For IV TNK or rt-PA administration, verbal consent is obtained from     patient or substitute decision maker.	
EVT 1 / IV/ +brombobsis	patient or substitute decision-maker	Attending Nouvelegist
EVT +/- IV thrombolysis	• For EVT +/-thrombolysis administration written consent is obtained	Attending Neurologist
consent	from patient or substitute decision-maker using appropriate	and Interventional
	Radiology Consent Form	Radiologist
	Part A: Explained to patient and consent obtained by	
	Neurologist	
	o Part B: Explained to patient and consent obtained by	
	Interventional Radiologist	

If patient is unable to consent, and there is no substitute decision-maker at KGH, verbal consent over the telephone may be obtained from substitute decision-maker	F	T	T
obtained from substitute decision-maker		<u> </u>	Attending Neurologist
In a case where patient is unable to give consent, and substitute decision-maker cannot be contacted, Neurologist and Interventional Radiologist (if EVT, IA rt-PA) is responsible for making decision to treat patient based on clinical judgment and interventional Radiologist (if EVT, IA rt-PA) is responsible for making decision to treat patient based on clinical judgment and interventional Radiologist (if EVT, IA rt-PA) is responsible for making decision to treat patient based on clinical judgment and interventional Radiologist (if EVT, IA rt-PA) is responsible for making decision maker in circumstances why consent could not be obtained must be documented in the patient or substitute decision-maker in circumstances where consent is withdrawn during TNK or 17-PA administration of 1. Clinical reassessment as part of ongoing monitoring and confirmation of consent or provide consent in the confirmation of consent or provide consent in the confirmation of the confirmation of consent in the confirmation of the c	=		
decision-maker cannot be contacted, Neurologist and Interventional Radiologist (if EVT, IA rt-PA) is responsible for making decision to treat patient based on clinical judgment  Rationale for treatment decision and reasons why consent could not be obtained must be documented  Fill in and sign Emergency Consent Form  Responsibility to assess and communicate with patient or substitute decision-maker in circumstances where consent is withdrawn during TNK or rt-PA administration +/-EVT  Clinical reassessment a part of ongoing monitoring and confirmation of consent  **Assess competency to provide consent  If IV Thrombolysis is Administered without EVT  Administration of IV  thrombolysis in CT Suite  **More to EV Circlical Care RN administer IV TNK; MD administers bolus dose of rt-PA while RN prepares infusion pump and begins rt-PA infusion (TNK does not require infusion)  Patient assessment & - Follow Acute Ischemic Stroke CCP re IV thrombolysis v-FeVT in IV-rt-PA infusion start in CT Suite (only for rt-PA NOTTNK)  Transport patient back to ED after CT Scan CNS Scale & VS q 15 min for 2 hours then q 1 hour for 22 hours, follow CCP  Assess patient's airway, comfort, and level of consciousness, sedation, and agitation  Continuous Sp0 - & Cardiac monitoring  **Monitor for angioedema & bleeding  **Keep patient NPO  Change patient into hospital gown  ECG post initiation of IV thrombolysis  Patient transfer to  D4ICU bed  **Acute Ischemic Stroke Thrombolysis (FVT QBP Order Set is completed in Entry Point  Communicate with D4ICU Charge Nurse re: bed planning; stroke patients' readiness for transfer  **Monitor in accordance with Acute Ischemic Stroke CCP while awaiting transfer to Unit making is interpreted  **Monitor in accordance with Acute Ischemic Stroke CCP while awaiting transfer to Unit making is interpreted with EVT After multiphase CTA/RAPID making is interpreted waiting in a first provide continuous if after hours  **Decision to proceed with EVT after multiphase CTA/RAPID making is interpreted in adding in addingl	unable to consent		
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Assess patient's airway, comfort, and level of consciousness, sedation, and agitation     Continuous SpO <sub>2</sub> & cardiac monitoring     Monitor for angioedema & bleeding     Keep patient NPO     Change patient into hospital gown     ECG post initiation of IV thrombolysis  Patient transfer to DAICU bed  Patient transfer to DAICU bed  Acute Ischemic Stroke Thrombolysis/EVT QBP Order Set is completed in Entry Point     Communicate with D4ICU Charge Nurse re: bed planning; stroke patients' readiness for transfer     Monitor in accordance with Acute Ischemic Stroke CCP while awaiting transfer to Unit  If EVT with or without IV Thrombolysis  Clinical decision re EVT     Decision to proceed with EVT after multiphase CTA/RAPID in and Interventional Radiologist     imaging is interpreted     Notify family-inform family to wait in IVR Waiting Room     Notify CT Suite or ED that IVR suite is ready  Nurse or Technologist if after hours DAICU or K2ICU Charge Nurse informs IVR of bed location  Patient Transfer to Control IVR Suite or ED that IVR suite is ready  Patient Transfer to Control IVR Suite or ED that IVR suite is ready  Attending Neurologist and Interventional Radiologist  Nurse or Technologist if after hours DAICU or K2ICU Charge	rt-PA infusion	CNS Scale & VS q 15 min for 2 hours then q 1 hour for 22 hours,	
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D4ICU or K2ICU Charge Nurse informs IVR of bed location     D4ICU or K2ICU Charge	<u>Location</u>	Notify CT Suite or ED that IVR suite is ready	
8 8			
Contact Ops Manager if delay in locating bed     Nurse & IR Nurse			_
1 0 , 0 1		Contact Ops Manager if delay in locating bed	Nurse & IR Nurse

Patient to receive IV	See above for IV thrombolysis	
thrombolysis	Prepare IVR Suite while patient is receiving IV thrombolysis in CT or ED	IR Nurse and IR Technologist
Prepare patient for EVT +/-IA rt-PA procedure	<ul> <li>Ensure patient is in hospital gown with no underwear</li> <li>If potential candidate for EVT, insert foley catheter (if patient is to receive TNK or rt-PA, insert foley catheter prior to TNK or rt-PA)</li> <li>Ensure 2 working IVs</li> <li>Transport patient to IVR when IVR suite is ready</li> <li>Prepare patient for procedure including:</li> </ul>	ED Nurse +/-IR Nurse  IR Nurse
	<ul> <li>Place patient for procedure including.</li> <li>Place patient on continuous SpO<sub>2</sub> &amp; cardiac monitoring</li> <li>Shave prep both groins-only if absolutely necessary</li> <li>Administer conscious procedural sedation &amp; follow Procedural Sedation Policy&amp; IVR Procedure Order Set</li> </ul>	
Monitor patient during procedure	<ul> <li>Follow standard IVR care processes including:         <ul> <li>Continuous SpO<sub>2</sub> &amp; Cardiac monitoring</li> <li>BP monitoring</li> <li>Assess patient's airway, comfort, and level of consciousness, sedation, and agitation</li> </ul> </li> <li>Monitor for angioedema and bleeding</li> <li>Keep patient NPO</li> </ul>	Interventional Radiologist and IR Nurse
Medical management of patient in IVR suite	<ul> <li>As a general principle, patients undergoing procedures are under the immediate care of the procedural physician although that physician may seek consultative support from referring and other physicians</li> <li>IR Technologists and IR Nurses assist with procedure</li> <li>Attending Neurologist is available in IVR suite to assist as needed</li> <li>Decision making regarding modifying/aborting planned EVT procedure</li> </ul>	Interventional Radiologists with consultation as required with the Attending Neurologist
Medical Management of Sedation	<ul> <li>Ordering sedation and analgesia as required per IVR Procedure         Order Set (Adult)</li> <li>When no Anesthesiologist is present, medical management of a         patient who develops complications in IVR suite, including         consultation of other medical services (i.e. Anesthesiology) is         initiated by Interventional Radiologist in consultation with the         Neurologist</li> <li>If there is concern about patient's airway or LOC in the IVR suite,         a code 99 for Anesthesiology is to be called</li> </ul>	Neurologist with Interventional Radiologist
	<ul> <li>If patient arrives intubated, decision is made to contact         Anesthesiology as needed</li> <li>If Anesthesiologist is present, patient monitoring, sedation and analgesia will be responsibility of the Anesthesiologist</li> </ul>	ICU Intensivist  Anesthesiologist
Femoral Sheath Removal	<ul> <li>Check ACT &amp; remove sheath per IVR Femoral Arterial Sheath Removal Nursing Policy &amp; Procedure &amp; Arterial Sheath Removal Order Set</li> <li>Apply bandage to puncture site</li> </ul>	IR Nurse
	<ul> <li>If Angio-Seal is not applied post procedure and femoral sheath remains in situ-complete Arterial Sheath Removal Order Set</li> <li>IR Nurse removes femoral sheath wherever the patient is located per Arterial Sheath Removal Order Set</li> </ul>	Interventional Radiologist IR Nurse

	<del>-</del>	
For Cases Where EVT is	In the case that EVT is aborted, the Ops Manager is contacted to	Attending Neurologist
<u>Aborted</u>	locate appropriate bed	
Transfer patient to	Notify D4ICU Charge Nurse or K2ICU Charge Nurse when	IR Charge Nurse or IR
Davies 4 ICU or K2 ICU	procedure is completed	Nurse if after hours
	Contact Ops Manager if delay in locating bed	
	Handover report in IVR to K2ICU Nurse/ICU Intensivist if patient	
	going to K2ICU bed	
	IR Nurse returns ED portable monitor to ED	
	Transfer patient with Stroke Team to D4ICU or K2ICU	
	Neurologist gives hand over report once patient has been	Attending Neurologist
	transferred to D4ICU or K2ICU	
	Protocol Coordination	
<b>Protocol Coordination</b>	Facilitate Stroke Protocol as it relates to external bodies	Regional Director &
<u>Functions</u>	(paramedic services, base hospital, central ambulance	Regional Stroke Best
	communication center, other hospitals)	Practice Coordinator,
		Stroke Network of
		Southeastern Ontario
	Facilitate the Stroke Protocol internally	Stroke Specialist Case
		Manager and Stroke
		Neurologist

### **Appendix A**

### **Acute Stroke Protocol Team Activation by Switchboard**

#### DAYS:

Staff Neurologist on Call and Neurology Fellow
Neuroradiologist
PGY2 (or PGY1 if PGY2 is post call)
ED Charge Nurse
ED Registration Clerk
Ops Manager
Stroke Specialist Case Manager (page)
CT technologist
Admitting
Core Lab
Regional Director, Stroke Network of Southeastern Ontario (leave message)

### After hours, weekends, and holidays:

Staff Neurologist on Call
Neurology Fellow (if on call)
Radiology resident on call
ED Charge Nurse
ED Registration Clerk
Ops Manager
CT technologist (on call)
Admitting
Core Lab
Stroke Specialist Case Manager (leave message)
Regional Director, Stroke Network of Southeastern Ontario (leave message)

When all have confirmed, call ED and report, "all have confirmed".

#### **Appendix B**

## Switchboard Guide: Endovascular 'EVT' Stroke Team External call Requesting EVT

#### External call requesting "Endovascular (EVT) Stroke TEAM" Calls for EVT can originate from - TELESTROKE, CRITICALL, Belleville General, Quinte Health Care NO MATTER HOW a caller ASKS for EVT stroke—We page BOTH the NEUROLOGIST on call for STROKE and the EVT Interventional Radiologist (IR) on call. Call goes to Neurologist on call for STROKE and the EVT Interventional If stroke patient is already at KGH Radiologist on call and Stroke protocol has been activated, the Neurologist is already treating patient and EVT treatment Interventional Radiologist (IR) might be considered and Stroke Doctors will connect with CritiCall and/or the referring team will look at patient's scan and decide if EVT is possible. If NO EVT If YES EVT Neurologist will request stroke protocol activation No further action to be taken If the Endovascular Team (Neuro After hours, the IR Attending may call switchboard and and IR) think EVT is possible two things happen: request we notify the IVR team for EVT (stroke) \*\*\*PLS Note—NO ONE OTHER THAN the Interventional 1. Neurologist will ask for stroke protocol activation to notify team radiologist Attending can request IVR TEAM for EVT callback activation 2. IR Attending may need to request IVR EVT team call back

PAGE GROUP # IVR TEAM for EVT 613-536-7557

Consists of 3 team members
2 IVR Techs and 1 IVR Nurse
Plus back-up stroke neurologists Dr Jin and Dr Appireddy