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| **NEURO** | **ALERT** | **Form A: Emergency Department***Place patient sticker here* |
| **Section 1: FLOWCHART** |
|  |
| **NEURO** | **ALERT** | **Form A: Emergency Department** |
| **Section 2: ‘NEURO ALERT’ − Emergency Department medical assessment** |
| **Blood glucose level** * > 3.6 mmol/l? *(If lower: treat before proceeding)*
 | □ **YES** □ **NO** |
| **Pre-morbid functioning*** Independent, and no history of severe cognitive dysfunction or terminal illness? *(If uncertain: assume normality)*
 | □ **YES** □ **NO** |
| **Time of symptom onset*** Symptom onset ≤ 4 hours ago? *(If time unknown: assume >4 hours)*
 | □ **YES** □ **NO** |
| **ROSIER score** |  |  |
| * Has there been loss of consciousness or syncope?
 | □ **YES (−1)** □ **NO (0)** |
| * Has there been seizure activity?
 | □ **YES (−1)** □ **NO (0)** |
| * Is there a new acute onset (or on awaking from sleep) of:
 |  |
| * + Asymmetric facial weakness?
 | □ **YES (+1)** □ **NO (0)** |
| * + Asymmetric arm weakness?
 | □ **YES (+1)** □ **NO (0)** |
| * + Asymmetric leg weakness?
 | □ **YES (+1)** □ **NO (0)** |
| * + Speech disturbance?
 | □ **YES (+1)** □ **NO (0)** |
| * + Visual field defect?
 | □ **YES (+1)** □ **NO (0)** |
| **ROSIER score total:** |  |
| **Is ROSIER score ≥ 1?** |  | □ **YES** □ **NO** |
| **If ‘YES’ to all questions:** | **Doctor responsible for this assessment:** |
| □ Activate **‘NEURO CALL’** via switchboard Time activated:□ Arrange bed in Resus or Majors□ Nurse to commence **‘NEURO CALL’** checklist | □ Emergency Consultant□ Senior Emergency Registrar |
| □ **Place patient sticker in Audit Book** *For any patient assessed as ‘NEURO ALERT’, regardless of whether ‘NEURO CALL’ initiated or not.**Audit Book lives in ‘NEURO CALL’ BOX, kept in Resus.* |

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| **NEURO** | **CALL** | **Form A: Emergency Department** |
| **Section 3: ‘NEURO CALL’ − Nursing checklist before CT scan** |
| □ **Assess vital signs** *(Resuscitate as appropriate)* |
| □ **Oxygen supplementation as required** *(Target SpO2 >95% in most patients)* |
| □ **Get ‘NEURO CALL’ BOX** *(Kept on top shelf in Resus bay)* |
| □ **Obtain IV access** *(Two cannulas, preferably in cubital veins, at least one 18G)* |
| □ **Arrange urgent bloods** *(Pre-printed request form in ‘NEURO CALL’ BOX)** + Venous blood gas *(Run on ED machine in Resus bay)*
	+ FBC, EUC, LFTs, coags

□ **Notify lab that urgent bloods are being sent** (either ED nurse or Stroke Medical Officer) |
| □ **Determine and document patient weight** |
| □ **Prepare for transport to CT-scanner at Darwin Private Hospital** |
| □ **Perform 12-lead ECG** *(only if this will not delay transfer to CT)* |

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| **Section 4: ‘NEURO CALL’ − ED nursing Stroke Care Bundle** |
| □ **Elevate head of bed to 30°** |
| □ **Nil by mouth until swallow assessment by approved person** |
| □ **Implement ED Falls Protection Package** |
| □ **Regular temperature check** *(escalate if > 37.5 °C)* |

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| **NEURO** | **CALL** | **Form A: Emergency Department** |
| **Section 5: ‘NEURO CALL’ − Nursing checklist pre-thrombolysis exclusions** |
| □ **Blood pressure** *(<185 mmHg systolic, AND <110 mmHg diastolic)* | □ **YES** □ **NO** |
| □ **Blood glucose level** *(> 3.6 mmol/l, AND < 22.2 mmol/l)* | □ **YES** □ **NO** |
| □ **Time of onset within protocol** *(<4.5 hours at time of starting thrombolysis)* | □ **YES** □ **NO** |
| □ **No contra-indications on CT scan** *(Check report with Stroke Team)* | □ **YES** □ **NO** |
| □ **INR not raised** *(<1.7)* | □ **YES** □ **NO** |
| □ **Platelet count not decreased** *(>100 ×109/l)* | □ **YES** □ **NO** |
| □ **Appropriate consent obtained** | □ **YES** □ **NO** |
| □ **‘YES’ to all the above questions?** *(If any ‘NO’: do not proceed with thrombolysis)* |
| **Nurse responsible for this assessment:**Name:Designation: Time: |
| □ **Alteplase order written on drug chart before administration** | □ **YES**  |
| □ **Maintenance saline infusion ordered** | □ **YES**  |
|  |
| **See dosing schedule and administration instructions****on laminated sheet in ‘NEURO CALL’ BOX** |

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| **Section 6: ‘NEURO CALL’ − Post-thrombolysis nursing checklist** |
| □ **Blood pressure** *(<185 systolic, <110 diastolic)* | □ **YES** □ **NO** |