American Heart Association. Mission:Lifeline Stroke

South Dakota Statewide Stroke Initiative (Stroke Triage and Time Tracking Card)

In an effort to collect real time data on a stroke patient and share key information with all clinician involved in the care and management of a stroke patient, the **SD Statewide Stroke Initiative** is asking EMS agencies and hospitals to utilize a **Stroke Triage Card** for real time data collection on patients with a stroke. The Initiative is asking that the **Stroke Triage Card** be kept with the patient during all phases of clinical management and patient transfers until the patient is received by Comprehensive Stroke Center or Primary Plus Stroke Center. The **Stroke Triage Card** is transferred as a key piece of clinical information/data representing all phases of clinical management. The tertiary Stroke Center receiving the patient will retain the original **Stroke Triage Card** as real time data on the patient and enter this information into the AHA Stroke Get With the Guidelines registry portal. Agencies and facilities involved in the clinical management of a stroke patient should retain a copy of the Stroke Triage Card information for their patient records. This specific data collection process aids in timely feedback to EMS agencies and hospitals that are involved in the care and management of a stroke patient. Thank you for your support and use of the **Stroke Triage Card.**

Stroke Triage Card - User Instructions

Initial Assessment For All Users (EMS and Hospital)

1. Identify a neurological patient with assessment criteria applicable to a BEFAST and VAN Assessment
2. Remove the **Stroke Triage Card** from the Envelope and follow/reference the BEFAST and VAN Assessment guidelines on the back side of the triage card
3. Document patient information/required data fields on the **Stroke Triage Card**
4. Initial Assessment/First Medical Contact Information is entered in highlighted yellow Sections
5. Place the **Stroke Triage Card** back in the envelope and keep the **Stroke Envelope/Stroke Triage Card** with the patient

EMS Instructions

6. Document EMS data fields on the **Stroke Triage Card** – highlighted in yellow
7. Transfer **Stroke Triage Card/Stroke Envelope** to the accepting ED nurse at the hospital on your arrival

Hospital Instructions

8. Enter hospital stroke information/data on the **Stroke Triage Card** (open data fields and lines requiring information)
9. Send the **Stroke Triage Card** and **Stroke Envelope** with the patient to the accepting tertiary Stroke Center.

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INSTRUCTION FOR USE

- Open packet and attach triage card to patient upon first medical contact and after intial data collection.
- Card remains attached to the patient throughout care management and removed only by the tertiary Stroke Center
- Utilize standardized timing whenever possible (cell phone). Complete all open data fields as a collaborative team throughout the care management process.

Triage card initiated by: EMS Agency Hospital

PATIENT/EVENT INFORAMTION

Date: _____ Patient Initials: _____ Private Vehicle Arrival: Yes No

First Medical Contact Time: _____ Agency/Facility Name: _____

EMS Agency Contact: _____ Initial Hospital: _____ Hosp. Contact: _____

EMS STROKE ASSESSMENT DATA Event crosses Time Zones: Yes No

Last Known Well Time: _____ Witnessed Onset: Yes No

Initial BEFAST Assessment Time: _____ Initial VAN Assessment Time: _____

EMS AGENCY

911 Dispatch Time: _____ EMS Arrive Scene: _____ EMS Depart Scene: _____

Last Known Well/Time of Discovery: _____ EMS Telehealth in Motion utilized: Yes No

Prenotification Report by EMS: Yes No Blood Glucose documented: Yes No

ED Arrival Time at First Facility (Door In): _____

First Hospital: TIME METRICS FOR STROKE

Initial Provider (MD/APP) Assessment Time: _____ At bedside on patient arrival: Yes No

Blood Glucose Documented: Yes No

Time CT Initiated : _____ EMS Direct to CT on Arrival: Yes No

Telestroke Time (online consult started): _____ Entity Contacted: _____

CT Read Time: _____

TimeThrombolytic administered: _____ Not Administered Not Applicable

Time Transfer Initiated facility (call time): _____

Time Ambulance or Air Medical notified : _____

Time of discharge from first facility (Door Out): _____

Transfer by: BLS Ambulance ALS Ambulance Critical Care/Air Medical RW FW Ground

Receiving Hospital Metrics

Arrival at Tertiary Stroke Center: _____ Accepting Stroke Center: _____

Thrombectomy time: _____

Key Performance Metrics in Stroke Patients

Door/FMC to Stroke Assessment within	10 minutes
EMS Scene time departure within	15 minutes
CT initiated within	25 minutes
CT Reported Results within	45 minutes
Door to Needle/Administration within	60 minutes
Door to Transfer Time within	90 minutes

The 60 Minutes DTN Goal Time Intervals

Door to physician	≤10 minutes
Door to stroke team	≤15 minutes
Door to CT/MRI initiation	≤25 minutes
Door to CT/MRI interpretation	≤45 minutes
Door to needle time	≤60 minutes

BE FAST

B - BALANCE
Sudden trouble walking, dizziness, loss of balance or coordination. *Perform bilateral index finger to nose test and bilateral heel to shin test.*

E - EYES
Sudden double vision or trouble seeing out of one or both eyes. *Assess 4 quadrants of visual field by having patient locate your hands and assess lateral gaze by having patient follow your index finger.*

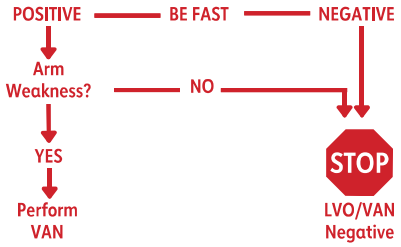
F - FACE
Sudden drooping or numbness on one side of the face. *Ask the person to smile or show teeth.*

A - ARM
Sudden numbness or weakness of the arm, especially on one side of the body. *Ask the person to raise and extend both arms with palms up. Does one arm drift downward?*

S - SPEECH
Sudden confusion, trouble speaking or understanding. *Have patient repeat a phrase such as "You can't teach an old dog new tricks."*

T - Last Known Well Time
If a patient has any of these symptoms, find out the Last Known Well Time & activate your local stroke response team immediately!

Test for Large Vessel Occlusion



VAN

V - VISION
Test for inability to see one or more quadrant AND new double vision, or blindness.

A - APHASIA
Name two objects AND repeat simple phrase, ex. "Today is a sunny day."

N - NEGLECT
Test for forced gaze to one side AND ignoring or unable to feel one side.

VAN or LVO Stroke Severity Scale POSITIVE if the patient has arm weakness AND any symptom(s) listed above.