Nurse identifies **change** in patient's condition suggestive of stroke

Nurse evaluates patient using **Cincinnati Stroke Scale** (any one finding is considered reason to contact house physician)

**Facial Droop**
- Normal: Both sides of face move equally
- Abnormal: One side of face does not move at all

**Arm Drift**
- Normal: Both arms move equally or not at all
- Abnormal: One arm drifts compared to the other
  (patient to hold arms at shoulder height with palms upward)

**Speech**
- Normal: Patient uses correct words with no slurring
- Abnormal: Slurred or inappropriate words or mute

Nurse pages **House Physician STAT.**

House Physician responds to evaluate patient.

If patient felt to be potential candidate for tPA, **House Physician** activates “Code tPA” (see attached flowchart of Code tPA team).

Utilize “Stroke Order Set” for required labs and tPA dosing (available on Unit 55 or ED)

House Physician, Flying Squad RN, and escort orderly transport patient to CT.

Stat CT/tPA completed and read by RADIOLOGIST with results communicated to House Physician.

Patient returns to room where **House Physician, Primary Physician and Neurologist** determine if appropriate to administer tPA.

If tPA appropriate, patient transferred to ICU.

Primary Physician contacted by Neurologist or House Physician for updates as appropriate.

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