

JOINT EVENT

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&
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Door to CT: Stalk the stroke**Mor Saba**

University of Haifa, Israel

Delayed diagnosis in patients with acute ischemic stroke in the Emergency Department (ED) still represented a blind spot in the assessment of quality health care indicators. To shorten the time for performing CT scan on purpose to give thrombolytic therapy within the reperfusion time window (IV rt-PA vs. Mechanical clot disruption). An intervention program was developed on purpose to promote rapid diagnosis and treatment for acute stroke patients. The intervention program includes a "Nurse Coordinator stroke" in the ED that supposed to correlate between the emergency service, to admit the patient in shock room, make rapid assessment, page the neurologist, order a head CT and ensure quick outgoing to the CT center (<15 minutes). In addition, cases that upheld the clinical guidelines were distributed to hospital staff by internal mail list. Cases that failed to meet the criteria underwent a full inquiry by the hospital safety and quality committee, which includes the involved ED & Radiologic staff, and the neurologist team. The median time to CT in 2016 was 31 minutes compared to 51 minutes in 2015 ($p < .001$). During the intervention period (2016), 109 patients (35.2%) adjust for thrombolytic therapy, when in 2015 only 79 patients (29.4%) received this therapy. 61 patients (56%) in 2016 and 50 (63.2%) in 2015 got reperfusion with IV rt-PA. Mechanical clot disruption was performed to 21 patients (19.2%) in 2016 and 15 (18.9%) in 2015. Integrated approach (IV rt-PA & Mechanical clot disruption) was performed in 27 patients (24.7%) at 2016 and 14 (17.7%) at 2015. After implementing the intervention more patients have reached neurologist evaluation within 10' (72.3%) compared to pre-intervention (56.6%) ($p = 0.04$); and more patients were stayed at ED less than 60' (68.2% and 41.7%, respectively, $p = 0.001$). It clearly appears that post- compared to pre-intervention, less time lags (in minutes) were measured in patients who their clinical guidelines were not achieved before the program. This was found for neurologist assessment (20.26 ± 7.29 vs. 34.55 ± 14.21 , respectively, $p = .03$), for total waiting time in ED (115 ± 32.25 vs. 164.61 ± 53.89 , respectively, $p = 0.01$) and time to CT scan (52.86 ± 13.51 vs. 70.25 ± 30.24 , respectively, $p = .004$). Attaching a case manager to perform rapid assessment of patient with acute ischemic stroke and perform head CT was proved beyond doubt. These findings make a prominent contribution to and have significant implications for quality of care for patients with suspected stroke admitted to an ED. These findings also encourage further such interventions to achieve better outcomes in the critical ED assessment stages.

MorSaba1683@yahoo.com

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