

# Georgia Paul Coverdell Acute Stroke Registry

## Monthly Update February, 2006

### Issue Contents:

<b>Update</b>	<b>1</b>
<b>Recruitment, 2006</b>	<b>1</b>
<b>ASLS</b>	<b>1</b>
<b>Northeast Georgia Medical Center's - Road to Stroke Quality Improvement</b>	<b>2</b>

The Coverdell Stroke Registry is a multidisciplinary effort to achieve excellent levels of care for acute stroke patients. Currently there are 24 hospitals participating in Georgia's registry. The registry is a collaborative effort between the Centers for Disease Control and Prevention, Coverdell's Steering Committee, Coverdell's Advisory Committee, and most importantly, the Coverdell Hospitals.

The Coverdell's Steering Committee is in the process of performing site visits to each facility. The site visits are used to answer any questions that may present, offer helpful materials and guidance, and to get a general overview of the facility's standings with stroke care.

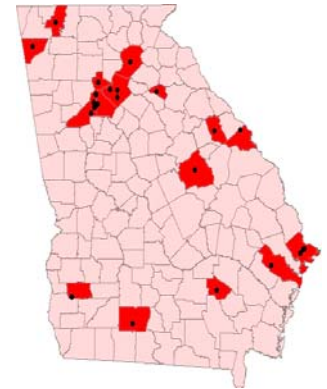
To date, 16 of the 24 participating hospitals have received visits by the steering

committee. Visits are scheduled according to the availability of the facility's stroke team and the committee members. If your facility has not received a visit please contact Kerrin Connelly at: [kerrin.connelly@heart.org](mailto:kerrin.connelly@heart.org) and give her your availability.

To further assist each Coverdell Hospital with reaching stroke excellence, an Advanced Stroke Life Support (ASLS) course will be offered on March 20, 2006. All facilities can register a maximum of two employees for this training. Participation is elective and registration will end on February 27, 2006. For more information please contact Kerrie Krompf at: [kkrompf@emory.edu](mailto:kkrompf@emory.edu) or view the ASLS website at: [www.asls.net](http://www.asls.net).

Hospital participation and inventory surveys were submitted via mail to each hospital randomly selected to participate in the registry.

If your facility has not received a survey, please contact Cortelius Wright at:



[ccwright@dhr.state.ga.us](mailto:ccwright@dhr.state.ga.us). If a survey has been received, please return to the address on the final sheet of the survey.

Please refer any questions, concerns, or ideas about the Coverdell Stroke Registry to Kerrie Krompf and she will present the information to the steering committee. We will address your comments in our upcoming newsletters.

### Quick Notes:

- February conference call had 34 people who participated.
- 17 of the 24 hospitals were on the February's call.
- A frequent performance evaluation by each facility is advised.
- Once facilities reach 85% compliance on a performance measure, they should adopt a new measure, while maintaining the other.

### RECRUITMENT, 2006

Georgia Paul Coverdell Acute Stroke Registry will begin its next recruitment phase soon. Currently there are 24 hospitals participating in the stroke registry. By the end of this recruitment phase we expect to double the amount of facilities participating in the registry.

This year's recruitment will consist of a letter being sent to randomly selected CEOs and Quality Improvement Departments, along with follow-up phone calls to the remaining non-participating facilities.

Other suggestions for recruitment ideas and techniques from current participants are welcome!

### ASLS, 2006

The University of Miami Advanced Stroke Life Support (ASLS) course is a simulation based curriculum developed to educate pre-hospital and hospital-based providers on the management of the acute stroke patients. The course addresses the pre-hospital, emergency department, and stroke unit management of patients through interactive discussions, hands-on workshops, multimedia videos, and standardized patients.

This course is being offered to assist Coverdell Hospitals in understanding why quickly identifying and applying treatment to patients with acute stroke may result in a reduction of mortality and disability. It will also provide attendees with the knowledge to train other hospital personnel.

## Northeast Georgia Medical Center's "Road to Stroke Quality Improvement"

Northeast Georgia Medical Center has focused many efforts to reach stroke excellence for the vast community that it serves. Northeast Georgia Medical Center began its journey by building collaborative efforts from within its organization. By including services from nursing, case management, pharmacy, physical therapy, occupational therapy, speech therapy, neuropsychology, nutrition services, and respiratory therapy they were able to construct a concrete base upon which to build an effective stroke program.

With the guidance of Trish Westbrook, Northeast Georgia Medical Center began participation in the Georgia Coverdell Stroke Program in 2003. Trish Westbrook is a neuro-clinical nurse specialist and a nurse practitioner who has dedicated 22 years to critical care. She is the coordinator of the stroke program and the clinical stroke team. Her many "hats" included: clinical practitioner, consultant, educator, researcher, and manager. Trish would like to share Northeast Georgia Medical Center's "Road to Stroke Quality Improvement" with other Coverdell Hospitals.

- 1) The project began by participating in Coverdell Stroke Registry in 2003.
  - a) After receiving the performance results for first year, we:
    - i) Determined that "We can do better" and then evaluated for:
      - (1) Weaknesses - didn't have a Stroke Unit, budget, FTE's, or physician support.
      - (2) Strengths – enthusiastic and dedicated.
    - ii) Realized that our resources were not optimal, but proceeded anyway.
  - b) Where to begin?
    - i) Used other models to develop a "t-PA Team."
      - (1) Team expected approximately ten t-PA cases per year.
      - (2) Administered t-PA seven times the first year.
      - (3) We were unable to justify having a 24/7 on-call team.
    - ii) Decided to develop a program that would benefit *all* stroke patients, not just tPA candidates.
      - (1) Developed a nine discipline Stroke Team: Nursing, Case Mgt, Pharmacy, Physical Therapy, Occupational Therapy, SLP, Neuropsychology, Nutrition Services, and Respiratory Therapy.
      - (2) Established performance rounds three times per week.
      - (3) Patients are pre-screened, and then discussed during rounds.
      - (4) Developed a team screening form to assure that all patients were evaluated in the same manner.
      - (5) Developed a set of stroke orders (excluding medications and most diagnostic tests).
        - (a) The order set was approved by Medical Executive to promote consistency and quality of care. The Stroke Team may write orders on behalf of the Attending MD.
        - (b) No complaints from MD's!
        - (c) Later added MBS, lipid profile, and HgbA1C.
      - (6) Developed additional support: Referral letter to PCP, "Secondary Prevention Recommendations."
    - iii) Based on the improvements demonstrated, a FTE for nurse was obtained to make *daily* rounds. The Stroke Clinician:
      - (1) Makes daily rounds.
      - (2) Collaborates with members of Stroke Team when needed.
      - (3) Makes rounds with each Stroke Team member at least once a month.
      - (4) Participates with the Stroke Team in a lunch meeting once a month. A different Stroke Team member leads the meeting each month. We review performance statistics, discuss opportunities for improvement, and provide education. Education may be a case study, journal article(s), videotape, or live presentation.
    - iv) Physicians are "coming around" supporting efforts, working collaboratively, and two of them are vying for the position of Stroke Director!
- 2) **Moral of the story:**
  - a) You *can* overcome a lack of resources with commitment and enthusiasm.
  - b) If you can demonstrate initial success, resources will follow.
- 3) Specific requests for topics from Kerrie.
  - a) The value of using a team approach.
    - i) It broadens the base of expertise, multiplies your effectiveness.
  - ii) It offers various perspectives on patient care needs.
  - iii) It heightens awareness throughout all disciplines.
  - iv) It enhances commitment.
  - v) It offers the opportunity to learn from each other.
  - vi) It draws group focus to a common goal.
- b) How did we develop an interdisciplinary team? We,
  - i) Obtained administrative support and organizational direction.
  - ii) Determined what disciplines should participate.
  - iii) Requested representatives from those disciplines.
    - (1) Be very clear about what characteristics are needed.
    - (2) Request representatives who are *interested* in stroke.
    - (3) Keep time commitments to a minimum – be considerate.
  - iv) Were concise and efficient in meetings and patient rounds.
  - v) Encouraged everyone to participate and offer their expertise.
- c) How to get staff buy-in? By,
  - i) Offering educational workshops.
  - ii) Streamlining processes and documentation.
    - (1) If it's easy, they'll use it.
  - iii) Celebrating improvement and progress.
    - (1) Emergency Department (ED) – celebration for increase NIH Stroke Scale utilization.
    - (2) Thank you notes for specific improvements (SCD's, swallowing screens, etc.).
    - (3) Thanks to ED doctors for 100% on "Lytic-Acute 2-hour" for December.
  - iv) Providing feedback on performance data.
  - v) Requesting and accepting constructive criticism and suggestions.
- d) If you don't have a dedicated unit, how do you screen the patients "What worked for us?"
  - i) Take the team to the patient. It provides consistency of care.
  - ii) At NGMC, patients may be on one of five general medical/surgical units, on two different campuses, or one of two critical care units.
- e) If you don't have a dedicated unit, how do you FIND patients?
  - i) It will depend on the available systems and computer infrastructure within the hospital.
  - ii) We locate patients by:
    - (1) Printing a census for the five medical/surgical units and their screening diagnoses.
    - (2) "Transcoding" that is entered when a pathway order set is used.
    - (3) Having the nursing or unit secretary enters a patient's name through a computer screen.
    - (4) Notifying the Stroke Clinician if they're seeing a patient that hasn't been screened.
    - (5) Dialoguing between the nursing staff and the charge nurses.
- f) Capitalizing on opportunities
  - i) Turn criticism into an opportunity.
    - (1) Complaints - ask for a letter to support improvement (Critical Care Committee).
    - (2) Physician turf guarding – ask his/her input on how we can better support them.
  - ii) When presenting successes to leadership, be prepared with a list of what you resources you need to go even further (FTE, \$, MD support, etc.).
  - iii) Advertise and celebrate success.
  - iv) When new staff/physicians come on board, enthusiastically orient them to your Stroke Program.

#### 4) Tips to Stroke Coordinators

- a) Focus on what you CAN do, rather than what you can't.
  - i) Commitment and enthusiasm can overcome many weaknesses.
- b) You can improve stroke care, even with few resources.
  - i) Small hospitals can do this also.
- c) Fit the Stroke Program into your hospital, rather than fitting your hospital into the stroke program.