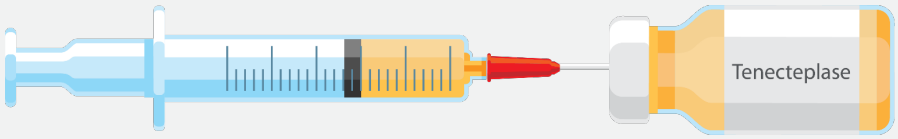
Clinical Workflow for Stroke Alert and Tenecteplase Treatment

NURSE
HUDDLE CARD



Patient arrives with acute neuro symptoms triggering → **Stroke Alert/Code and Neuro Team Assembles**

- ☐ **Patient Assessment** to include blood pressure assessment, IV access, measured weight, point of care glucose, and vital signs
- ☐ Patient to CT with stroke kit/supplies
- ☐ Await CT results – **DO NOT PULL AND PRE-MIX TENECTEPLASE**
- ☐ Obtain tenecteplase from ADC in CT scanner room or go back to ED or from stroke kit
- ☐ **Prepare tenecteplase** in designated clean area:
  1. Remove shield assembly from supplied 10mL syringe.
  2. Withdraw 10mL of Sterile Water using syringe with dual TwinPak cannula device.
  3. Inject entire 10mL of Sterile Water into tenecteplase vial and directing towards the powder.
  4. Gently swirl until completely dissolved. Color should be clear to pale yellow.
- ☐ **Independent Double Check** with a RN or other verifier according to facility practice, to include:
  - Ordered dose (Maximum dose is 25mg/5mL)
  - Medication
  - Patient weight
  - Prepared dose
  - Co-signer documents IDC in eMAR

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☐ Perform **Time Out** verbally with Provider to confirm ordered dose and readiness for administration. Time out includes the following:

- Does patient have any contraindications?
- Did the patient give consent for administration?
- Does patient have dedicated line for tenecteplase?
- Is the patient's BP < 185/110?

☐ **eMAR Documentation** against profiled order:

- Scan tenecteplase bar code
- Review admin criteria: patient weight, dose, volume and dosing calculation
- Co-signer verifies above and documents in the eMAR if required by local facility

☐ **Administer** tenecteplase to patient. (Maximum dose should not exceed 25mg)

☐ **Waste** remaining tenecteplase in vial (at least 5mL) according to facility policy.

☐ Thrombolytic **Monitoring** to include:

1. Assessment for **Hemorrhagic Conversion** complication, to include but not limited to:
    a. Decreased LOC, Headache, Acute BP changes, Nausea and Vomiting, Increase in NIHSS >4 points, and Radiographic changes.
2. Assess for **Angioedema** by performing oral checks as follows:
    a. Every 15 mins x2 hours
    b. Every 30 mins x4 hours
3. Major **bleeding**
4. **Vital Signs** and **Neuro Checks** completed minimally as follows:
    a. Every 15 mins x2 hours
    b. Every 30 mins x6 hours
    c. Every 1 hour x16 hours

Notify provider immediately for signs and symptoms of hemorrhagic conversion, angioedema, abnormal vital signs per physician orders (especially elevated BP), and acute changes in neuro checks.