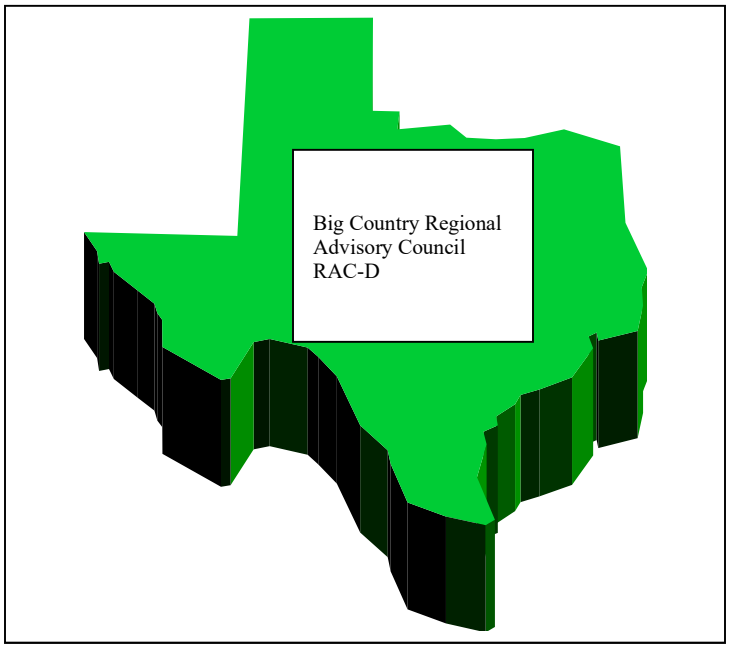
Big Country Regional Advisory Council (BCRAC)
Trauma Service Area (TSA) - D
Regional Stroke Plan

Big Country Regional Advisory Council
2257 Industrial Blvd Ste A
Abilene, TX 79602

2027



For the state service delivery area including Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Shackelford, Stephens, Stonewall, Taylor and Throckmorton

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Approved October 21, 2026

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Introduction
Organization and Service Area

The Big Country Regional Advisory Committee (RAC-D) is comprised of the Central West Texas counties of **Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Shackelford, Stephens, Stonewall**, **Taylor and Throckmorton**. BCRAC represents the Trauma Service Area-D, a geographic area as defined by the Texas Department of State Health Services and is a non-profit organization.

Service Area/Facilities

The BCRAC Service Area is comprised of fifteen (15) rural counties and one (1) urban county (Taylor). Located in Taylor County, Abilene is home to 125,182 residents with Taylor County estimated population at 143,208 residents. Abilene is a regional commerce center for residents of west central Texas. The area economy is based on agriculture, oil and gas production, education, and manufacturing. Of the top 20 largest employers in Abilene, 5 are directly involved in health care in some format and employ a minimum of 5,000 employees at any given time. Located three hours from Dallas/Fort Worth and four hours from San Antonio, Abilene serves a regional trade area and is considered the primary catchment area for our EMS system. Abilene is home to Dyess Air Force Base, home of the B-1 bomber squadron, which employs some 6,000 civilian and military personnel. The population in the remaining fifteen county service area is estimated at 161,529 for a total service area population of 304,737. Individual counties and estimated populations in this service area include*:

COUNTY	**POPULATION**	**SQ. MILES**	**HOSP./TRAUMA LEV.**
Taylor	*148,813*	*916*	*Hendrick Medical Ctr North -II* *Hendrick Medical Ctr South -undesignated*
Brown	38,711	944	*Hendrick Medical Ctr* Brownwood -IV
Callahan	14,017	899	No Hospital
Coleman	7833	1281	Coleman Co. Med. Ctr-IV
Comanche	13,950	937	Comanche Co. Med Ctr-IV
Eastland	17,725	926	Eastland Memorial Hospital-IV
Fisher	3672	899	Fisher Co. Hospital-IV
Haskell	5499	903	Haskell Memorial Hospital-IV
Jones	20,334	928	Anson Gen. Hospital-undesignated
Knox	3307	850	Knox Co. Hospital- IV
Mitchell	9018	911	Mitchell Co. Hospital- IV
Nolan	14,738	912	Rolling Plains Mem Hosp - IV
Shackelford	3105	914	No Hospital
Stephens	9351	896	Stephens Memorial Hosp - IV
Stonewall	1245	916	Stonewall Mem Hosp - undesignated
Throckmorton	1572	912	Throckmorton Co. Hosp - IV
TOTALS	**312,890**	**14944**	**(US Census Bureau 2022)**

(*Italicized county, population, and square mileage indicates “primary” catchment with all others indicating “secondary” catchment.)

TSA-D
BRAC-Stroke

MISSION

The BCRAC Stroke Committee's mission is to provide a comprehensive continuum of quality health care for all stroke patients in TSA-D, through continuing Education, Prevention and Performance Improvement.

VISION

The BCRAC will provide leadership in our region to improve outcomes and reduce disability related to stroke.

ORGANIZATION

The BRAC strives to provide the infrastructure and leadership necessary to sustain a stroke system of care within the 16 county region. Representatives from regional hospitals, EMS providers, Air transport and other first responders collaborate to ensure appropriate triage, transfer and guideline-directed care is provided to stroke patients in the region. Designated stroke facilities' leadership provides benchmarks, feedback and clinical practice guideline updates to ensure care is consistent across the continuum. The BRAC shares continuing education opportunities related to stroke and is involved in providing stroke education to the public through members of the Stroke Sub-Committee Hendrick Health's Pre-Hospital Committee meets quarterly outside of scheduled RAC meetings.

Regional Stroke Plan

This Plan has been developed in accordance with generally accepted national stroke guidelines and procedures for implementation of a comprehensive Emergency Medical Services (EMS) and Stroke System plan. This plan does not establish a legal standard of care, but rather is intended as an aid to decision-making in general patient care scenarios. It is not intended to supersede the physician's medical judgment to order treatment.

GOALS

1. To reduce the morbidity, mortality and disability of the stroke patient population.
2. To recognize facilities' capability to treat stroke patients within TSA-D based on the State requirements for Stroke Center Designation.

OBJECTIVES

1. To improve the overall care of stroke patients by rapidly recognizing the signs of a stroke and transporting the potential stroke patient to the appropriate facility, in the appropriate time, with the appropriate level of resources.
2. To identify facilities and corresponding level of stroke management within TSA-D.
3. To improve patient outcomes in the region.

DISCUSSION

While it is recognized many of the facilities within TSA-D may elect NOT to seek Stroke Center Designation, in effort to provide the optimum in patient care and thereby improve outcomes, BCRAC has elected to utilize the criteria set forth by the State of Texas for Stroke Center Designation as the foundation in identifying individual facility capabilities.

REGULATORY AGENCIES AND GUIDELINE RESOURCES FOR STROKE CARE

1. DSHS Stroke Designation | Texas DSHS
   A) All designated stroke facilities must participate in the regional and statewide stroke systems.
   B) The Governor's EMS and Trauma Advisory Council (GETAC) Stroke Committee of the Department of State Health Services (DSHS) Stroke Committee recommend the designation of four levels of state recognized stroke centers/facilities as follows:
      Level I – Comprehensive
      Level II – Advanced
      Level III – Primary
      Level IV – Acute Stroke Ready

   C) Designation requirements by level
      1. For DSHS Stroke Designation levels I, III, and IV Refer to the Brain Attack Coalition Publications
         a) Recommendations for Comprehensive Stroke Centers (2005)
         b) Revised and Updated Recommendations for the Establishment of Primary Stroke Centers (2011)
         c) Formation and Function of Acute Stroke Ready Hospitals (2013)
      2. For DSHS Stroke Designation level 2, Refer to EMS Trauma Systems Section Stroke Facility Designation Advanced Level II Stroke Designation Department Approved Guidelines (May 2023)
      3. Each designated stroke center is required to maintain designation requirements.
      4. Refer to DSHS website for complete list of hospitals or centers meeting state approved criteria and their Stroke Center/Facility designation.
      5. Online stroke resources
         - American Heart Association (www.americanheart.org)
         - American Stroke Association (www.strokeassociation.org)
         - Brain Attack Coalition (www.stroke-site.org)

DESIGNATED STROKE FACILITIES

If a BRAC hospital or center fails to meet the criteria for a state stroke center/facility level designation for more than 6 weeks or if a hospital or center no longer chooses to maintain state stroke center/facility level designation, the hospital shall immediately notify, by certified mail return receipt requesting, the DSHS, local EMS, and governing RAC.

STROKE SYSTEM QI Regional data is presented quarterly at the Pre-Hospital Committee Meetings. The Stroke Sub-Committee meets quarterly prior to RAC meeting for process improvement in the region. DSHS designated Level II and Level III stroke facilities report data to the RDC through the STRAC.

STROKE DATA INDICATORS:

EMS

Pre-Hospital Cincinnati Stroke Scale Performed and Documented in EMS record
Stroke Severity Screen Performed and Documented in EMS Record
Pre-Hospital Stroke Alert
First Medical Contact to Endovascular Thrombectomy

REGIONAL FACILITIES

Door to CT < 20 min
CT interpretation <45 min
CTA performed or Stroke Severity Screen documented (ischemic)
Door to thrombolytic (alteplase or tenecteplase) <60 min
Door in Door Out Goal <90 min
Door to Puncture (endovascular thrombectomy) <90 min

Confidentiality - All information and materials provided and/or presented during QI meetings are strictly confidential.

TSA D - EMS SERVICES

1) Abilene Fire Department-EMS
2) Air Evac Lifeteam 63-Abilene
3) Air Evac 115- Eastland
4) Air Evac 52- Brownwood
5) Citizens EMS
6) Comanche County EMS
7) Cross Plains EMS
8) Dublin EMS
9) Eastland Memorial Hospital EMS
10) Eula VFD
11) Fisher County Hospital District EMS
12) Hamlin EMS
13) Haskell County Ambulance Service
14) Sacred Cross EMS-Coleman
15) Jim Ned VFD
16) Knox County EMS
17) Lifeguard Ambulance Service- Brownwood
18) MetroCare Services Abilene-L.P.
19) Mitchell County EMS
20) Native Air of Snyder
21) North Runnels Hospital EMS
22) Potosi Volunteer Fire Department
23) Ranger Fire Department-EMS
24) Sacred Cross EMS
25) Scurry County EMS
26) Shackelford County EMS
27) Stamford EMS
28) Sacred Cross EMS – Stephens County
29) Stonewall County Ambulance Service
30) Sweetwater Fire Department
31) Taylor County EMS
32) Throckmorton County EMS

Contact information can be found on the Big Country Regional Advisory Council Home page
EMS Providers | Mysite (bigcountryrac.org)

TSA-D Regional Hospitals

Level II (Advanced-Thrombectomy Capable) Stroke Centers

Hospital Name – Town		IV thrombolytic?	Thrombectomy Capability?	Neurosurgery Capability?
Hendrick Medical Center North – Abilene		YES – Tenecteplase (including extended window with CTP)	YES	YES

Level III (Primary) Stroke Centers

Hospital Name – Town	IV thrombolytic?	Thrombectomy Capability?	Neurosurgery Capability?
Hendrick Medical Center South – Abilene	YES – Tenecteplase (including extended window with CTP)	NO	NO
Hendrick Medical Center Brownwood– Brownwood	YES - Tenecteplase	NO	NO

Level IV (Acute Stroke Ready) Stroke Center

Hospital Name – Town	IV thrombolytic?	CT	CTA
Coleman County Medical Center - Coleman	YES - Tenecteplase	YES	YES

Regional Support Facilities (without designation)

Hospital Name – Town	IV thrombolytic?	CT	CTA
Comanche County Medical Center -Comanche	YES Tenecteplase; Alteplase	YES	YES
Eastland Memorial Hospital – Eastland	YES - Tenecteplase	YES	YES
Fisher County Hospital – Rotan.	YES - Tenecteplase	YES	YES
Haskell Memorial Hospital – Haskell	YES - Tenecteplase	YES	YES
Stonewall Memorial Hospital – Aspermont	YES – Both Alteplase/Tenecteplase	YES	YES
Knox County Hospital – Knox City	YES Tenecteplase	YES	YES
Mitchell County Hospital – Colorado City	YES - Tenecteplase	YES	Yes
North Runnels	YES - Tenecteplase	YES	NO
Rolling Plains Memorial Hospital – Sweetwater	YES - Tenecteplase	YES	YES
Stephens Memorial Hospital – Breckenridge	YES - Tenecteplase	YES	YES
Throckmorton County Hospital - Throckmorton	NO	NO	NO

Emergent Access Facilities

Hospital Name-Town	IV thrombolytic?	CT	CTA
Anson General – Anson (24-hour Emergency Room only	YES - Tenecteplase	YES	YES

No Hospital
Callahan County, Shackelford County

Below are lists of possible facilities that may be utilized outside TSA D. These facilities are identified as within 250 miles of TSA-D Lead Facility in Abilene.

- **Level I Designated Stroke Facilities outside TSA-D**

  Texas Health Harris Methodist Fort Worth
  1301 Pennsylvania Ave
  Fort Worth, TX 76104
  817-250-2000

  UT Southwestern Medical Center
  5323 Harry Hines Blvd
  Dallas, TX 75300
  214-648-3111

  Medical City Fort Worth
  900 8th Street
  Fort Worth, TX 76104
  217-336-2100

  Covenant Medical Center
  3610 22nd Street
  Suite 301
  Lubbock, Texas 79410
  806-725-1630

For other Texas designated stroke facilities, refer to
www.dshs.texas.gov/dshs-ems-trauma-systems/stroke-system-development/texas-stroke-facilities

Stroke Patient Transport - Stroke patients in TSA-D are transported according to patient need, availability of air transport resources, and environmental conditions. Ground transport via BLS or ALS ground ambulance is available throughout the Region. Air Medical transport (fixed and roto wing) is also available in this Region.

PRE-HOSPITAL TRIAGE

GOAL: Patients with acute stroke symptoms should receive expeditious EMS dispatch and response. EMS personnel should be knowledgeable in the assessment, management, and triage of suspected stroke patients. Personnel should be skilled in the performance of stroke screening and in determining the timing, onset and nature of the symptoms. Because some acute stroke treatments require the provision of definitive care within a specific time frame, EMS personnel should communicate with the receiving facilities as soon as possible and transport the patient to the nearest appropriate acute care facility.

PURPOSE: To ensure the prompt availability of medical resources needed for optimal patient care, each patient will be assessed for the presence of neurological changes using a prehospital stroke screen and severity screen for possible LVO, and concurrent disease/predisposing factors.

SYSTEM TRIAGE

GOAL: Patients with an onset of stroke symptoms < 4 ½ hours should be taken to the closest regional facility with the following capability:

- Interpreted computed tomography (CT) imaging scan is available within 45 minutes of patient arrival.
- Thrombolytics can be administered within 60 minutes of patient arrival.
- Physician is available within 10 minutes of patient arrival.

Patients in the extended thrombolytic Window 4.5 to 9 hours since last known normal (LKN) should be taken to the closest regional facility with the following capability:

- CT Perfusion (CTP) to determine eligibility for thrombolytic therapy.

If stroke symptoms ≥4 ½ to <24 hours and the Stroke Severity Scale is positive for possible LVO, transport to nearest designated stroke facility with CTP and thrombectomy capability. Hendrick Medical Center North is the only facility with thrombectomy capability in TSA-D.

Patients with an onset of stroke symptoms occurring outside of the thrombolytic window of <4.5 hours or greater than 9 hours of LKN and with a LVO screen negative should be transported to the nearest designated stroke facility for initial diagnosis and treatment.

In any situation, unstable patients (ABC's, cardiac arrest, etcetera) should be taken to the nearest facility for stabilization.

This plan is based on accepted best practice guidelines but does allow for patient preference.

BCRAC PREHOSPITAL TRANSPORT GUIDELINES FOR STROKE

SUSPECTED STROKE

Assessment Guidelines:

- Onset S/S
- Time "last known normal"
- Complete Vital Signs
- Blood Glucose*
- Pre-Hospital Stroke Scale
- Stroke severity scale to assess for possible LVO
- Thrombolytic Checklist
- 12-Lead ECG

*Consider other etiologies such as hypoglycemia and seizure.

Minimum Treatment Guidelines:

- Oxygen per TDP to keep SPO2 >94%
- IV NS TKO (as per skill level)
- Consider antihypertensive agent for blood pressures above 220/110
- Rapid transport to appropriate facility as indicated.
- Divert to the closest hospital for airway management or stabilization.
- Consider Air Medical transport for patient deterioration.

Transport decision should be based on time of onset as appropriate.

If >60 minutes for ground transport, consider Air Medical Transport to decrease time.

LKN <4.5 hours	*LKN >4.5- 9 hours	LKN 4.5 - 24 hrs	LKN Beyond 24 hours (Or undetermined time of onset)
Closest Stroke Facility with thrombolytic capability	LVO screen positive, transport to thrombectomy capable stroke LVO screen negative- transport to closest Stroke facility with CT Perfusion	If LVO screen positive, transport to closest facility with thrombectomy capability >9 to 24 hrs with LVO screen negative, transport to nearest Stroke receiving facility	Non-emergency transport This patient is outside the window for reperfusion.

***Extended Thrombolytic Window**- Late presentation or wake up stroke. If wake up stroke in extended window- Estimated LKN is midpoint of sleep.

HELICOPTER ACTIVATION

GOAL: Air transport resources will be appropriately utilized in order to reduce delays in providing optimal stroke care.

DECISION CRITERIA TO ACTIVATE:

1. If the expected transport time is excessive (>60 minutes), activation of air transport resources should be considered.
2. Capability of closest appropriate facility (See System Triage section).

HOSPITAL TRIAGE CRITERIA

GOAL: Facilities will rapidly identify potential stroke patients and deliver evidence-based care.

OBJECTIVES:

1. Ensure each stroke patient is rapidly identified and accurately assessed based on the last known normal. The patient will be treated appropriately or transferred to the nearest acute care facility for appropriate intervention. (See page 8 for regional facility imaging and thrombolytic capability)
2. Ensure prompt availability of medical resources for optimal patient care.

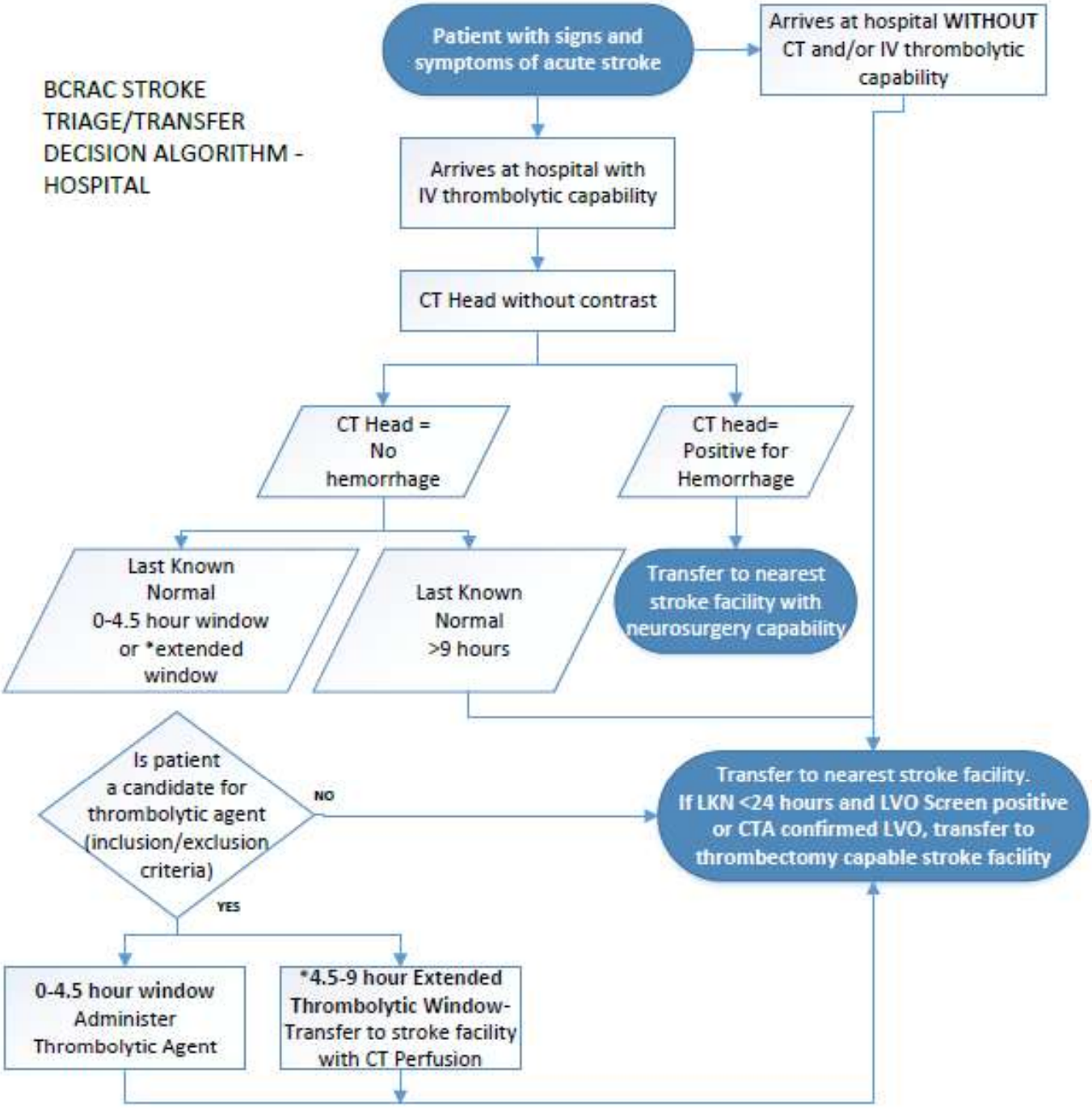
INTER-HOSPITAL TRANSFERS

GOAL: Inter-hospital transfer plans within TSA-D will ensure stroke patients requiring additional or specialized care and treatment beyond a facility's capability are rapidly identified and transferred to appropriate facilities.

OBJECTIVES:

1. Ensure all regional hospitals make transfer decisions based on the BRAC Stroke Triage/Transfer Decision Algorithm – Hospital (See page 13).
2. Identify standards of care for stroke treatment
3. Consider early air medical activation for inter-hospital transfers.

BCRAC STROKE TRIAGE/TRANSFER DECISION ALGORITHM - HOSPITAL



Inter-facility Nursing Handoff:

- Time of Last Known Normal
- Patient's presenting symptoms
- Medications administered (including pior to hospital arrival)
- Home Medications (please include any anticoagulants/antiplatelets)
- Imaging performed and results
- NIHSS/Glasgow Coma Scale
- Abnormal Labs, POCT Glucose
- Vital Signs
- IV access
- Family contact information and relationship

***Extended Thrombolytic Window-**
Late presentation or wake up stroke.
If wake up stroke in extended window-
Estimated LKN is midpoint of sleep

Large Vessel Occlusion (LVO) Screening Tool
V -Vision
A -Aphasia
N -Neglect

FACILITY DIVERSION:

Goal

TSA-D stroke facilities will communicate "facility diversion" status promptly and clearly to regional EMS and other facilities in order to ensure that stroke patients are transported to the nearest appropriate stroke facility.

System Objectives

1. To ensure that stroke patients will be transported to the nearest appropriate stroke facility.

2. To develop system protocols for regional facility and stroke diversion status:
    - Situations which would require the facility to go on diversion
    - Notification/activation of facility diversion status
    - Procedure for termination of diversion status

3. Regional stroke care problems associated with facility diversion will be assessed through the BCRAC Committee and/or Pre-Hospital Committee.

If the designated stroke facility has an interruption in capabilities or capacity critical to the evaluation and treatment of a stroke patient, the facility will immediately notify local EMS providers, referring facilities, and their RAC through EMResource's electronic communication with time-stamp capabilities.

STROKE PLAN RECOMMENDATIONS

Last Known Normal (LKN) Accurate communication of last known normal- not when symptoms found

Pre-Hospital Stroke Scale – Regional EMS providers should assess and document the pre-hospital stroke scale such as the Cincinnati Pre-Hospital Stroke Scale (CPSS) or FAST-ED.

Stroke Severity Score (LVO Screening Tool) – Regional EMS providers and hospitals should assess and document the LVO screening. ED physicians and staff should be familiar with these tools. Examples: VAN or RACE score.

NIH Stroke Scale – It is recommended facilities have a written protocol utilizing the NIH Stroke Scale.

Glasgow Coma Scale- Clinical scale used to reliably measure a person's consciousness after a brain injury

IV thrombolytic Checklist – The facility should utilize the regional IV thrombolytic Checklist or a similar checklist with the same information.

Thrombolytic Therapy Administration Protocol* – This criterion refers to a facility having a written protocol for administering thrombolytics if the facility will be administering thrombolytics.

- **Alteplase for ischemic stroke: 0.9 mg/kg with Max dose 90 mg.** Give 10% of total dose administered as a bolus over 1 minute. Then the remainder of the dose over 60 minutes.

OR

- **Tenecteplase for ischemic stroke** 0.25 mg/kg with a max dose of 25 mg IVP over 5 seconds or FDA approved weight range dosing.

*If regional facility is **unable** to administer a thrombolytic within the 4 ½ hour window, facility should communicate to EMS provider of need to bypass to nearest facility with capability. See "Facility Bypass". Patients with symptoms in the extended window (4.5 to 9 hours) should be considered for thrombolytic therapy using CT Perfusion and inclusion/exclusion criteria.

24/7 STAT CT* – This criterion is desired. This criterion refers to the ability to have a CT completed and read within 45 minutes of arrival to ED.

*If no CT capability, facility should communicate to EMS provider of need to bypass for patients with signs and symptoms of stroke.

24/7 STAT CTA* – This criterion is desired. If unable to perform CTA or results are pending, regional facility should screen for large vessel occlusions (LVO) for patients presenting with signs and symptoms of an acute ischemic stroke with negative CT head and Last Known Normal <24 hours.

*Do not delay transfer if results are pending. Call accepting facility with results while patient is in route.

TRANSFER AGREEMENTS –It is recommended that regional referral facilities have transfer agreements with a level I, II or III Stroke Center.

AGREEMENTS WITH EMS PROVIDERS – The facility should have at least one written agreement with an EMS Provider allowing stroke patients to be treated as priority one/emergent.

RECOMMENDED STAFF EDUCATION

NIH Stroke Scale Education – It is recommended facilities have written protocols outlining NIH Stroke Scale education for all nursing staff and physicians involved in stroke care.

Other Stroke Education – It is recommended EMS providers and facilities provide stroke education for personnel.

Optional Tracking Tool for Sending Hospitals

Optional Tracking Tool for Stroke Center/Receiving Hospital Use

Stroke Sending Facility Tracking Form

Patient Sticker	ED Physician:
	Primary Nurse:
	Tele-Neuro Physician (if applicable):

#	Time	Steps	Document in EMR
		First documented time of Patient arrival (Private Vehicle or EMS)	
1		LKN (Time of Last Known Normal)	YES
2		Stroke code/alert called	YES
3		Physician Notified	YES
4		STAT CT Head (Door to CT <20 min)	
		STAT CTA Head and Neck OR LVO Screening Tool (LKN <24 hours) **Do not delay transfer for read.**	
5		Baseline NIHSS _____ Baseline GCS_____	YES
		NIHSS <15 min prior to lytic (if applicable)_____	YES
6		Pt meets criteria for thrombolytic? YES/NO WT in Kg: _____ Thrombolytic Administration Time _____ Drug_____ Dosage_____	YES
7		Monitor NIHSS and VS every 15 minutes x 8, then every 30 minutes	YES
8		VAN (Visual/Aphasia/Neglect) or CTA confirms LVO _____Positive; _____ Negative Stroke Severity Screen for Large Vessel Occlusion **(If positive, place HOB Flat)**	YES
9		Call for acceptance of stroke patient (name of facility)_____	
10		Communicate last NIHSS and VS to EMS/Air Transport and when next assessment is due	
11		Keep patient NPO until screened for dysphagia (including meds)	YES
12		Discharge/departure time_____ (NIHSS____ and GCS _____ <15 min prior to departure)	YES

See Appropriate	NURSING:	TIMES:
• BCRAC Stroke Triage/Transfer Decision Algorithm-Hospital	O STAT POC glucose O Result?_____ O EKG O Initiate IV line O Draw labs	• Stroke Code: LKN 0-6 hrs • Stroke Alert: LKN 6-24 hrs • Door-Provider: <10 min • Door-CT: <20 min • EKG: <45 min • CT results: <45 min • Door-Thrombolytic: <60 min (Goal <30-45 min) • Door-in-Door-Out Goal <90 min NOTE: If hemorrhage and on anticoagulant, goal for reversal agent <60 min
	O troponin O CBC,CMP, O PT/PTT O Continuous Cardiac Monitoring O 02 per TDP ____ L/min via	

BP Parameters:	Pre-thrombolytic BP <185/110- Maintain at <180/105 Permissive hypertension if not a thrombolytic candidate and no hemorrhage Hemorrhagic stroke BP goal SBP <140 -Maintain SBP 130-150

TRACKING TOOL IS NOT A PART OF THE PERMANENT RECORD

RAC-D Stroke Tracking Tool-Receiving Center

Optional Tracking Tool for Stroke Center/Receiving Hospital Use

BRAC Stroke Tracking Tool- Regional Hospital

Patient Sticker	ED Physician:
	Tele-Neuro Physician:
	Admitting Physician:
	ED Primary RN:

#	Time	Steps	Document in Flowsheets
1		First documented time of Patient arrival (Private Vehicle or EMS)	
2		LKN	YES
3		Stroke code/alert called	YES
4		ED Physician notified _____	YES
		Physician at bedside _____	
5		STAT CT Head (per stroke protocol)	
6		STAT CTA (per stroke protocol) immediately after CT Head	
7		Baseline NIHSS _____	YES
		AND NIHSS Prior to lytic _____	YES
		AND NIHSS post lytic (see checklist for timing)	YES
		Handoff NIHSS (Perform together. Receiving RN documents) _____	
		GCS on arrival _____ NIHSS on arrival _____ NIHSS and GCS <15 min prior to transfer (Document on MOT)	YES
8		Yale Swallow Protocol PASS/FAIL/ or Deferred due to exclusion criteria NPO until screened for dysphagia	YES
9		Pt meets criteria for thrombolytic? YES/NO Thrombolytic Administration Time _____ Cosignature required for dose calculation ____	YES
10		Tele-Neuro consult Time Tele- Neuro on screen/telephone?	YES

See Appropriate Algorithms	NURSING:	TIMES:
• ED Stroke Code/ Alert • Hemorrhagic - • Ischemic LVO -	O STAT POC glucose O Result?_____ O EKG O Initiate IV line O Draw labs	• Stroke Code: LKN 0-6 hrs • Stroke Alert: LKN 6-24 hrs • Door-Provider: 10 min • Door-CT: <20 min
	O ISTAT TROPONIN O CBC,CMP, O PT/PTT O Continuous Cardiac Monitoring O 02 per TDP (SpO2 >95%) ____ L/min via	• EKG: <45 min • Door-Lab Results: <45 min • CT results: <45 min • Door-Thrombolytic: <30-45 min (Must be <60 min)
BP Parameters:	Pre-thrombolytic BP <185/110- Maintain at <180/105 Permissive hypertension if not a thrombolytic candidate and no hemorrhage Hemorrhagic stroke BP goal SBP ≤140 -Maintain SBP 130-150	

NOT PART OF THE PERMANENT RECORD!

BRAC Stroke Committee October 2025

TRACKING TOOL IS NOT A PART OF THE PERMANENT RECORD

Thrombolytic Eligibility Criteria (Ischemic Stroke):

Inclusion criteria:

If any of the following is not checked, a thrombolytic agent should NOT be administered. I If ALL of the following are checked, proceed with the checklist

- Age 18 years or older.
- Clinical diagnosis of Ischemic Stroke causing a measurable neurologic deficit.
- Time of symptom onset well established to be less than 4.5 hours (270 minutes).

Exclusion criteria:

If any of the following is marked, DO NOT administer thrombolytic agent (tenecteplase or alteplase)

Patient History:

- Ischemic stroke or severe head trauma in the previous three months.
- History of previous intracranial hemorrhage.
- Intra-axial intracranial neoplasm, vascular malformation, or aneurysm.
- GI malignancy.
- Gastrointestinal hemorrhage in the previous 21 days.
- Intracranial or intraspinal surgery within the previous three months.

Clinical:

- Symptoms suggestive of subarachnoid hemorrhage.
- Persistent blood pressure elevation (SBP greater than 185 or DBP greater than 110 mmHg).
- Active intracranial hemorrhage and/or internal bleeding.
- Presentation consistent with infective endocarditis.
- Stroke known or suspected to be associated with aortic arch dissection.

Hematologic:

- Active bleeding diathesis, including, but not limited to platelet count less than 100,000/mm3.
- Current anticoagulant use with international normalized ration (INR) greater than 1.7, or prothrombin time (PT) greater than 15 seconds, or activated partial thromboplastin time (aPTT) greater than 40 seconds.
- Therapeutic doses of low molecular weight heparin received within last 24 hours (e.g. to treat venous thromboembolism (VT) and acute coronary syndrome (ACS)); this exclusion does not apply to prophylactic doses (e.g. to prevent VTE).
- Current use (i.e. last dose within 48 hours in a patient with normal renal function) of a direct thrombin inhibitor or direct factor Xa inhibitor with evidence of anticoagulant effect by

laboratory tests such as aPTT, INR, ecarin clotting time (ECT), thrombin time (TT), or appropriate
factor Xa activity assays.

Head CT:

- Evidence of hemorrhage.
- Extensive regions of obvious hypodensity consistent with irreversible injury.

Warnings:

With careful consideration and weighting of risk-to-benefit, patients may receive intravenous thrombolysis despite one or more warnings. **Intravenous tPA appears to be safe and may be beneficial for patients with these criteria, including patients taking oral anticoagulants with an INR less than 1.7.

- **Advanced Age (80 years or greater).
- **Oral anticoagulants use regardless of INR.
- **Stroke severity - too severe (NIHSS* greater than 25). *National Institute of Health Stroke Scale
- **Combination of both previous ischemic stroke and diabetes mellitus.
- Only minor and isolated neurologic signs or rapidly improving symptoms.
- Serum glucose less than 50 mg/dL (less than 2.8 mmol/L).
- Serious trauma or major surgery within the past 14 days.
- History of gastrointestinal bleeding (remote) or genitourinary bleeding.
- Seizure at the onset of stroke with postictal neurologic impairment.
- Pregnancy.
- Arterial puncture at non-compressible site in the previous 7 days

Intra-arterial Intervention: For suspected Large Vessel Occlusion (LVO) AND if the time of symptom onset is less than 24 hours, contact Neuro interventionalist or consider transfer to higher level of care for intra-arterial intervention at thrombectomy capable stroke center (level II).

Suspected large vessel occlusion (LVO) patients should be considered for thrombolytic administration prior to transfer using inclusion/exclusion criteria.