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Chapter	Changes/Clarifications	New additions
PM	**Moved medical director to here** **Update:3/1/16 Please note that CR.1f contains a description and some examples of criteria that could be used to select a designated medical director in the event that the organization does not have a neurologist or a neurosurgeon to provide leadership and clinical guidance to a stroke program. This is not to be confused with the requiremnt that the medical director should have eight hours of education annually as specified in SM.2 CR.7a.**	
QM	**QM.7 CR.2 Spelled out performance measures** **(2015) Deliniated time benchmarks and included the ones for Target Stroke.**	**Added time for target stroke** **UPDATE: 11/1/2015 Target Stroke Phase II is a Campaign Program from the American Stroke Association and it is voluntary to encourage stroke centers to try to meet that guideline to improve tPA administration percentages. You will see that we have made that a goal for 2015/2016 in the information section in the front section of the document.** **Goal to be achieved/ not to be scored** **UPDATE: 11/1/2015 tPA time has not been scored however starting in Jan 1, 2016 –tPA given in less than 60 minutes at least 75% of the time will be scored as an NC-2 in the first year and if there is no improvement the second year, it could be scored as an NC-1, in 2017. The 45 minute goal of tPA admin will not be scored unless there is an update from the AHA that it is the new expectation and not a goal. The target goals for various times were put into the**

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		standards in parentheses to highlight the different time goals that would be needed if the organization was to adopt the 45 minute goal. They are not to be scored either at this time.
PC	**PC.4 Expanded ER section: CR.3** **PC.4g** **Spelled out tPA post monitoring times in grid as too many hospital continue to miss them** **UPDATE: 11/1/2015** **Please use the timelines in the grid to review the medical records. They are essential to the safety of the patient.** **UPDATE: 3/1/16** **Pay particular attention to the Pre-bolus neuro and vital signs time frame. Vital signs and neuro status should be no more thatn 15 minutes before the bolus to obtain current patient status.**	**New section on EMS/ (2015)** **1 requirement ERs usually know this information stroke patient priority destination protocols utilized by EMS providers that address transport of stroke patients, in accordance with law and regulation, but for some, may look new.** **If this is not available, it may be scored as an NC.2** **2 CR.2e The program and EMS determine circumstances and alternate protocols in which the PSC would be on diversion and not able to accept patients.** **3 New section for telemedicine..only applicable if they use it /must have description, process and equipment** **UPDATE: 3/1/2016** **Please note that the host hospital requirements for credentialing for telemedicine must be followed.** **UPDATE: 11/1/2015** **There have been questions about the wording used in QM.7 CR.2f that states: Computer link from when determined medically necessary by ED physician ≤ 20 minutes. There was a misprint and it should read:** **CR.2f Connected computer linkage (or on phone) to telemedicine consultant from when determined medically necessary by ED physician ≤20 minutes**

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		UPDATE: 3/1/2016 **Many questions on this one still so another clarification . This is requiring that the ED physician can be coneccted to the consultant, ready to talk and review the case within 20 minutes of when they make the request for the consult. As stated above, this may mean by phone, computer or whatever means an organization has to connect with the consultant.**
	AST (2015) **CR.3a The PSC will require 8 hours of education and training to the members of the Stroke Team personnel, initially and annually.** **Note: The PSC may determine the personnel assigned to the AST that could be required to receive less than the minimal required hours of education and training. This will be at the discretion of the PSC to exclude any personnel, with justification, when they are not specifically dedicated to the PSC. (See SM.2 CR.7 for detailed requirements) on ALL members and others.** **UPDATE: 11/1/2015** **Note that organizations are still asking questions on this, one situation is because they have decided/determined that some or all of the ED nurses would be considered part of the team and therefore they would now need eight hours of**	**NEW (2015)** **PC.8** **CR.3 The stroke protocols (pathways) will include standardized order sets for the diagnosis, evaluation and management of the acute stroke patient following current AHA guidelines that address:** **CR.3a Vital signs and neurological function checks** **CR.3b Blood pressure management parameters** **CR.3c Blood glucose control** **CR.3d Parameters to treat fever** **CR.3e Oxygenation management parameters** **CR.3f Laboratory tests (including point of care)** **CR.3g Brain imaging** ***CR.3h Inclusion and exclusion criteria***

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	education, rather than the 4 initial and 2 annual hours for ed nurses, but refer to the note on PC.7 CR.3.a.	
	PC 12 Diagnostic Tests This is not new and not as a requirement, but is talking about availability and documentation, WHEN ordered.. Troponin was added , if ordered. CR.1a Documentation should include completed diagnostic studies including complete blood count, chemistries, coagulation studies, troponin and, when chest x-ray, pregnancy test, etc. as ordered. Indicated, an ECG. UPDATE: 3/1/2016 Clarification on troponin. There is no requirement to order troponin on any case unless the physician determines it is needed.	PC.9 TRANSFER AGREEMENT all new (New in 2015) PC.14 (New in 2015) Patient/Family/Community education. New section a) patient/family should be included in education b) PSC shall offer at least 2 annual programs to educate the public c) shall evaluate the community outreach initiatives by measuring the knowledge in the community about the causes, signs and symptoms of stroke as well as emerging stroke prevention strategies
MS		
NS		
SM	Job description can be in the form of an addendum or described in the program narrative as competencies.(2015)	
PR		Expanded consent section/but not new Follow host hospital policy for grievance and other rights
MR		MR.4 CR.6a (2015) Document reason eligible patient did not receive tPA
PE	Follow host hospital policies (2015)	

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	Notes on Issues to be aware of: 3/1/2016	
	Issue	**Description of findings**
	Nimodipine	
CSC PSC	**Oral Nimodipine is indicated to reduce poor outcome related to aneurysmal SAH (Class I, Level of Evidence A)**	
	Metric 15: Percentage of patients with documented aneurysmal SAH for whom Nimodipine treatment (60 mg every 4 hours or 30 mg every 2 hours) is started within 24 hours of diagnosis and for whom such treatment is continued until 21 days after the hemorrhage or until discharge if they are discharged 21 days after the SAH.	**There have been several findings on this metric. While most SAH protocols have included the Nimodipine order as stated in the metric, the administration of this medication has consistently not been adherent to the order. There have been many discrepancies between the orders and the administration times. There have been instances that the medication has been given within 35 minutes of the last dose to 5 hours, when the order has been for 30mg every 2 hours as well as when ordered as 60 mg every 4 hours, the variation of administration has been from 90 minutes to 7 hours.**
		Comment: *It would most likely be a good idea to review some medical records to determine if your organization has the same issue. Nurses have stated that the reason for this variance is that this medication was not identified as a critical drug, however, while all medications might not be identified as time critical, the fact that the medication was ordered more frequently should trigger the "classification", at least the two hour order.*