Introduction

Surgical procedures put selected patients at an increased risk for stroke. Many surgical patients have underlying co-morbid stroke risk factors such as hypertension, heart disease, diabetes and dyslipidemia. Stroke risk is further complicated by the subsequent hypercoagulable state and inflammatory response from surgery, as well as by holding anti-thrombotic and anti-coagulation medications prior to surgery. As such, Post-Anesthesia Care Unit (PACU) staff need to be aware of the increased risk for stroke, regardless of “inpatient” or “outpatient” status.

Deltas of previous workflow:

- Delays in transport to CT scan, imaging acquisition, and treatment decisions
- Patients were at increased risk for anesthesia and surgical recovery complications in the ED due to lack of specialty training

Barriers to an efficient workflow process:

- As a consulting team, the stroke code team requires a quick response from anesthesia, PACU staff and stroke response team.
- PACU staff aimed to optimize the management of peri-operative patients at risk for stroke with a standardized rapid assessment and incorporating safe peri-anesthesia transitions of care.

Background

The post-anesthesia care unit (PACU) on the main campus of this institution is a level one trauma surgical center that specializes in surgical procedures across the fields of neurology, oncology, gynecology, cardiothoracic and gastroenterology. The PACU is a 24-hour care area consisting of a combined Phase I and Phase II assessments.

In 2022 the organization performed 23,678 surgical cases; 11,342 surgical patients at risk for stroke with a standardized anesthesia and surgical care pathway, as well as by holding anti-thrombotic and anti-coagulation medications prior to surgery. As such, Post-Anesthesia Care Unit (PACU) staff need to be aware of the increased risk for stroke, regardless of “inpatient” or “outpatient” status.

Gap Analysis/Methods

An interdisciplinary committee was formed to identify workflow gaps for stroke. Based evaluation and treatment delays. The collaborative committee, consisting of PACU nursing and medical leadership, and stroke program nursing leadership, reviewed current state including volume and processes of stroke codes during the prior year. The committee aimed to streamline the diagnostic and intervention phases of acute stroke care, regardless of “inpatient” or “outpatient” status.

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