AMERICAN HEART ASSOCIATION

STROKE AND COVID: A NURSING PERSPECTIVE

12:00 PM - 1:00 PM CENTRAL

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>> Good morning, everyone, and welcome to Stroke & COVID: A Nursing Perspective. We are just going to go over if you also prepare us for this presentation. As a reminder, there are no CEs. If you don't have any technical issues, you can refresh your screen. If that doesn't work, please contact customer service.

University. She is surfer -- certified in neuroscience and stroke nursing and is a member of several professional organizations, including AANN, ANPC and AONO. She and her husband of 30 years are blessed with two adult children and six beautiful grandchildren. And our last presented today is clear and Madison. She has over 34 years of nursing aspirants in the area of neuroscience nursing. Her experience includes interventional care, critical care, and medical surgical nursing. She provides consulted services in the area of stroke center developing an ongoing maintenance of acute care services to support delivery of stroke care.

She works with a large stroke center that supports six acute-care campuses, her expense includes overseeing operations, ongoing performance and quality and staff develop. She has led her got multidisciplined routine in becoming one of the first centers nationally to achieve competence of stroke center certification.

Claranne is actively involved in stroke care delivery both locally and nationally. Bunkers in several American Stroke Association in American Neurosciences Nursing Committee task force. She has been a national speaker on topics related to stroke care delivery and target to mature management post cardiac arrest. She has been an author for the American Nurses Association core curriculum, the -- series for critical practice and has been published in multiple journals. Claranne received her bachelor of science in nursing from East Strassburg University and created a Master of science in nursing. She is certified at the American Board of Neuroscience Nursing as ACN, RN, and as a assistant professor of nursing at East Strassburg University. So growing our next generation of hopefully some neural stroke nurses.

So I'm going to hand it over to Tiffany.

>> Hi. Thank you for this opportunity to have a conversation from the nursing perspective about stroke and COVID. I'm going to take a minute in between the slides to shift. I'm going to be talking about how the pandemic has really affected our stroke care. As it relates to volume and eventually community perspective and some of the things that as a community we have changed in the health care line to impact the volume of stroke patients.

No disclosures.

So what we know about stroke care and the pandemic is really just a drop in the bucket. In fact, our literature really only extends as far as data is recorded on how it has impacted our stroke care regime of 2020. So there is a lot to be studied and understood how it's really made an impact on our stroke care and outcomes. But what we do know is there is a clear association reported between cerebrovascular disease and COVID-19 period and that coexisting stroke and COVID-19 negatively influence our patient outcomes including higher mortality as well as functional outcomes.

Finally, really stroke here has been disrupted, and I think we all know that worldwide, and especially our stroke centers.

So early observations period when I say early observations, I'm talking about that first surge. Really, as far as our -- is extended. So across the nation, hospitals have reported a 30%-40% decrease in the value of patients presenting with stroke. There was a decrease in reperfusion therapies including TVA for large occlusion, and that TIA and minor stroke symptoms, patients with minor stroke systems are saying home for fear of contracting the virus.

And then there has been a reported increase in time from last known -- to hospital arrival in time from arrival to imaging.

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Along the same lines, in general, with EMS at the hospital world, the number of EMS activations also went down. There was a 30% decrease in activated altogether and activations of 911. So this is kind of interesting, think later on they are starting to see an increase. However, in the first surge we noticed an increase in cardiac arrest once they did arrive to the patient's homes.

So where have all of our stroke patients gone? I know we all thought that decrease in stroke patients and scratched our head as far as why. So as a stroke community, we speculated a few reasons, but also reported from patient interactions in the hospital and some literature. So this is Arizona. It was everywhere. People took stayhome very

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stroke code. We really wanted to highlight that while our stroke centers have these benchmarks that we are working towards, that would be a goal and not necessarily an expectation period we are trying our very best. And I know we all are.

But also they highlighted that stroke systems of care was needed now more than ever to just collaborate from hospital to hospital system. And I think we have done a great job of that as well.

I think, too, we need to consider from back to me in the era of COVID-19. This was a

And Vince transport to the stroke center. We have depleted hospital resources. Beds and staff availability. Some hospitals are now keeping their patients versus transferring them to a higher level of care given that the center might not have space for that patient population.

And in Arizona and many other parts of the country we have a centralized transfer center, kind of a sorting hat if you are a Harry Potter fan, but really the centralized transfer center across health care systems, making sure that COVID is distributed to where the resource is, but what about our stroke patients. How they are being dispirited to stroke centers or otherwise.

And finally, thrown back to me, a lot of hospitals have had a change in process, as far as not allowing the direct endovascular advanced imaging and when do wen back to me gnIhealto

>> Thank you so much, Tiffany that was great. You can enter your questions online, but I'd also like to reach out to Claranne and Jen to get comments on how this has impacted your community.
>> I think we have seen exactly what Tiffany described early on. We saw a drop off of our stroke numbers. And I think your question that your ending on our dead on. I think

she shared. Challenges on the stroke nursing unit, issues surrounding discharge and that postacute care follow up, and then the support of our teams as we try to navigate this storm that we are all in the middle of.

And some of you may be sick of hearing the term, unprecedented, as I am, but I have to say it is a very good descriptor of what we are facing.

And so another fallout that I wanted to share with you all is going into this, pre-2020, all of our hospitals had a pandemic plan. And many others men have been involved in serving on our hospital incident command systems, being part of planning for the pandemic that we all thought would come eventually.

But the distinctive thing about this particular crisis is there is no playbook. There is no plan, no algorithm that really took into account the intensity of this particular illness or the lack of resources or the lack of accessibility to resources that we would all face. And I think that it has particularly impacted our very vulnerable stroke populations.

So one of the articles that I found, one of the studies that I found, was an exploration of clinickps f acopulk ex thi10]2 ˇ(ac40dB)2 (f)2 (4 (g i)6 (10 f)2 (TDf)2 he l)6 (ac3 (t)14 (pi)63u3(f)2 (l)2 (wn (o)10 (n

staffing adjustments to help minimizing exposure, separating those with overlapping skill sets.

And when we think about the changes or the adjustments that we have had to make on stroke nursing units, I think the one that has impacted our patient population the most has been visitor restrictions, especially early on. We had no visitors. Now, we allow one designated visitor per patient. And that creates a significant struggle for our patients, for their families, and for our teens. On the front and for stroke teams, getting the history, getting the information surrounding onset and discussing treatment options becomes even more challenging that it can be under normal circumstances.

So and going forward, helping to keep those families connected with the care teams requires time. It requires engagement. It requires adoption of technology that maybe we weren't comfortable using before.

And helping our patients to stay connected to their family members is critically important. But again requires time and creates stress on an already stressed system.

Other issues tha

challenging. Access to specialists and cardiologists may be impacted. And we are seeing telemedicine everywhere, where maybe we didn't see it before.

The other thing that we have had to address is how do we train our team members in a time that we are gathering together to do that hands-on training for everything may not be the best approach. We have had to learn what can be taught virtually what needs to be on the ground and how do you provide that safely for everyone? So I anticipate that we will learn more about this going forward this year, but it is a challenge for our teams.

Community education also present some challenges. How do you do a virtual health fair for your local senior center? Utilizing our marketing contacts, social media, we did a couple of virtual events where we had some of our team and our community members log in, but we are going to be have to be more savvy and apply these -- this technology to this task as well.

And another point that I wanted to highlight, we are all super focused on our stroke and neuro populations – appropriately simple. But we are part of the whole hospital response to the pandemic, as part of the hospital response, the community response picks up what we have seen and what I'm sure many of you across the country have seen, is that as we are rolled up into that surge planning and implementation, it has impacted our resources that historically have been designated or dedicated to our patients. So we have seen neuro impact care units repurposed as COVID intensive care units. We see neuro critical care teams pulled into the care of COVID patients. Stroc8a4M Tw 31.92 0,

So a big challenge that we have been a big responsibility that we have is to continue to work together as a team. This pandemic has exacerbated chronic challenges that we all

And as far as training goes, it has been very difficult to train our stroke nurses, but also travelers. So in the first surge, we had a lot of travelers coming in and it's how do you get them up to speed. But in addition to that learning is an entirely new patient populace in such as COVID and all the nuances that go with that.

So we have developed huddle sessions and recall them stroke blitz sessions. So they are a down and dirty education at the bedside one-on-one with nurses. It's real-time education. And working to build that into our education for stroke. So that is applied education to the bedside and incidentally keeping up with the changes going on.

And finally, I would just say that I tend to be a glass half-full person picks up when going through hard times struggles or something so big as this pandemic, I really tend to look at what I'm seeing is a positive, pulling that out. So some of the things, just thinking about nursing practice and stroke care as limiting some of the documentation, which is always a positive, I think.

If we really need to be documenting certain things, it's a question, and developing new plans. Especially around TPA, I know we all have our protocols in place, but really, let's evaluate the patient outcomes based from these changes. So from a researcher cap, I think of opportunity there. So that's a lot to have been said, and I will hand it over to Claranne.

>> Any comments?

>> I just would like to add, I think it's been amazing, they said 2020 was the year of the nurse, and certainly the nurse has so much on the front lines at the bedside. I just have been awed by some of the innovative ways nurses have stood up through the pandemic, from taking things outside the room so they can keep titrating, some of the ICUs were using baby monitors to connect with the patients and not within feel like they are long. As well as some of our teams using iPads to do discharge instructions and sort of involve the family as much as possible with kind of connecting. I think early on we all saw that separation of family being at the bedside and really leveraging think technology from iPhones and iPads to kind of get connected to those loved ones. So again, really amazing stuff that is going on.

>> Great. Now, I will hand it off to Claranne, who will talk about a stroke surveyed during the pandemic.

>> Thank you. So just when you thought your having enough fun, then we get to recertification for early on through the pandemic, re-certifications were kind of put on hold. And as the pandemic continued on, we needed to sort of reinstate having the reviews that we are also excited to host when they come up or when you are starting off your first review.

So with that being said, I'm going to try to get the slides.

Where I work, we are a comprehensive stroke center. We are an hour north of Philadelphia. I have a company has a stork center on campus, and our open review was June 10-September 8. So we were right in the middle of the summer going into the fall and expecting a review. So that time kind of came and went again and we said okay, now what? We also have a primary stroke center that was open for review through November 6. So in past circumstance we would have our CSC review, have recovery time, and that host our view at the other campus.

We were lucky when the numbers dropped, to get that phone call from the joint commission saying we have you on the schedule. We are coming to visit you. And we are going to do your other school by staying a secondary. So we were excited to have that happen. It would be our fifth review.

So it couple things about getting ready. As we all know, it's a daunting experience getting ready for your site survey. So they have surveys, and they have put on hold some of the calls, but the actual surveys they are looking at the numbers ended up in a plan whether to come on-site or to do it virtually.

Soil tell you a little bit about our experience. I will say that they just posted a review process guide period for those of you who have been through this, that's your Bible. That is your go to resource when you're getting ready for a survey.

With that being said, I did reach out to my friend, Jeannie, to say can you touch base with the joint commission and see if they have any words of wisdom for today's presentation. And they basically sent back a reply that they were doing reviews, both on-site and off-site. The review process has not really changed. However, the off-site process has a little bit of pre-review steps. And I will go over those with folks so that you can walk away with the information that you might need to prepare.

You are having the virtual review, the information that you see -- receive, it will be Zoom platform. So for many others, we have become connected to whatever platform the organization is using. Be it WebEx, Microsoft Teams.

So the semicolon platform has a few caveats with it. So you need to get a handle on what that looks like.

What starts as a phone call with your executive to go over and test your technology. So they give you that opportunity to make sure that you can connect. You have to have the ability to have a shared drive and be able to postdoc you met on that shared drive to share with the reviewer.

There will be a ready date once you have done your test connection, they will test about connecting with you and make sure your platforms are able to stand up to your can then make sure you can up load the document to the shared drive.

Then you will get your ready date. You're ready date means that they can move you into the scheduling window and then you will still get your seven day notice.

The tricky thing with the ready date as you start collecting your cases from that ready date. So when they reviewed us, they did not take any of the charts from March 1 until our ready date. And then from our ready date to the actual on-site visit, with a separate list.

The other piece is that it really turns a two day survey into a three-day survey. When you're doing this virtually, they start the afternoon proceeding and the start of your survey with doing your opening conference.

So your opening conference is done the afternoon prior to the start of the review and gives them the opportunity to go over the orientation of that program.

So creating a presence. Many of us who have been through surveyed know you would like to get that review in, we have signed them up, we try to figure out kind of where they are from, what kinds of things are there hotspots. How do we do this. Doing this virtually is a little bit harder. So you need to sort of have a plan for this. So you're not going to be able to get that room full of your leadership. You are going to need to consider how they're going to introduce themselves using the web platform. So much like Tiffany and Jennifer are online today, sharing their WebCams, we practice with our leaders to do the formal introductions at the beginning. Can you turn on WebCam and

say hello.

And then meeting minutes.

through it. I found the reviewers were very flexible. They did understand that bedside staff need to be providing care. It was easier for us to have a classroom, a large room where we could go to review those charts and then have multiple people have the ability to share their screen.

So if you have someone who has ED documentation, they are working with that ED chart. And then you share the screen when you are looking at the charging that is on the MedSurg floor.

Competence assessment and credentialing. We never this is two years of information. You want to think about how you're going to present this online. For many of us, we have been scrolling documents, and this can make someone very seasick when you are whipping through something to get to it.

The reviewers were very direct with giving us directions on what they wanted to see. Give us a clear checklist of information they would be looking at. Practice that. Because many of you are going to have to have multiple people share their screens to kind of pull it together with the documentation that it has.

If you're the past have had nurse educators that have had files that had certificates and things that staff have completed and the years passed, think ahead. Because all of this needs to be digitally able to be projected. So you need to scan that in and you need to be able to look at that. We did find that they did count those hours. They wanted to see the 8 hours for both years. They were serious about doing that.

The core team, having that pre-prepped and ready to go. The 80% reports for the ED folks, the review of the process, they want to see those for both years. And again, sending a clear instructions and the fact that this has to be live.

Looking at your matrix. What does your job discussion say? If your job description says you need to have trauma hours, you need to show the trauma hours. So is a copy him(am)3 (2bot)12 (h

on that link and reach out to the American Heart Association staff. If you have any questions and would actually like to reach out to one of our panel today, feel free to shoot us an email and we will put you in touch with them.

A lot of people are absolutely concurring with a lot of your issues identified. One question I want to put out and actually, I sound like Barbara Walters from 20/20, can each of you name or is there any COVID intervention that has turned out to be a benefit that you think should be really kept post pandemic? Claranne, you can go first.

>> I think overall, as Tiffany mentioned, looking at the monitoring and seeing if there is a way to skinny that down a little bit for our nursing staff. That is one thing. I think the other piece is documentation, we made some changes to our documentation to rearrange things so it was a little bit tighter for the nursing staff and it would seem-o 0.006 Tw 0.28u0 l

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>> And I would add, I agree with all the things that you ladies listed. I think for me, the collaboration and the strengthening of the partnerships across disciplines, across facilities, we need to keep that. We do.
>> So we know we could probably talk for another two hours to these ladies, but we are finishing up we are going to thank our panelists, and Amanda, you want to close out today?
>> Everyone, click on your email for certification of your attendance. And make sure to check your junk. Thank you for attending.
>> Thank you, everyone. Take care, ladies. Everyone stay well.