On 4/11 my preceptor and I came in and took report from the night RN. Our 75-year-old male patient came to the ED from Snyder via EMS during the night with a last known well two days prior to admission to the ED. The patient was having expressive aphasia and slurred speech. When my preceptor and I went to the bedside to assess the patient at 0700, he was AOX4 with all symptoms resolved. At approximately 0940, the patient's daughter came to the nurse's station and stated, "It's happening again." We went back to the patient's bedside to assess the symptoms. During our assessment the patient was unable to identify common objects and his aphagia and slurring were back. We then called the stroke coordinator to ask what needed to be done since this was a new onset of symptoms. After speaking to the coordinator, we called a code stroke to the ED. We then had the stroke team at bedside and made our way to CT quickly. After we returned to the ED, the physician determined that TNKase was called for. We gave the dose and took the patient to SICU 3 for closer monitoring.

I was feeling intrigued in the beginning since I knew that calling a code stoke overhead in the ED is uncommon. The most important feeling during this incident was urgency. We rushed the patient to CT immediately after the code was called and the stroke team was at bedside. I was impressed with the teamwork that I saw. Everyone had a role, and this made the event run smoothly. We had mild difficulty getting the patient to stay still in the CT machine, but my preceptor was able to throw on some lead and held his hands and kept him calm.

In analyzing the situation, I was able to make an educated guess as to why the patient had a re-onset of symptoms. He had a carotid ultrasound 20 minutes before the symptoms reappeared. I was able to use my knowledge from previous modules to know that our rapid recognition and activation of the code aimed at maximizing the chances of survival and recovery. I also knew that if indicated, Tenecteplase would be administered to the patient for an ischemic stroke. Tenecteplase must be administered within 4.5-24 hours after the onset of symptoms. The impact of different perspectives made me think that TNKase might be tolerated better in younger patients with less comorbidities but that in stroke patients that meet all criteria, it is the best option.

I learned that the new protocol for new onset of stroke-like symptoms in the ED is to call a code stroke overhead. This situation also further confirmed to me that asking questions and teamwork are key skills to have in nursing. I also learned that a multi-disciplinary approach is key in a code situation.

Overall, this situation went as smoothly as it could. My preceptor and I were quick to assess the patient and quick to call for clarification on what next steps to take. This experience has taught me to be investigative and to ask more questions. I will be able to use this experience to further my practice and apply these learnings to other events by studying the protocols the hospital has in place.