

Updated Primary Stroke Center Certification Appendix for the Disease-Specific Care Manual

This article provides a revised Primary Stroke Center Certification appendix for the *Disease-Specific Care Certification Manual, Second Edition*. It updates standard references appearing in the “Brain Attack Coalition Recommendation/Joint Commission Expectation” cross-walk. The entire appendix is presented for your conven-

ience. New language is indicated with underline and deleted text is indicated with strikethrough. For questions about disease-specific care certification and this appendix please visit the Joint Commission’s Web site at <http://www.jcaho.org> or call 630/792-5291. ▲



OFFICIAL PUBLICATION OF UPDATED APPENDIX

Appendix: Primary Stroke Center Certification

APPLICABLE TO DISEASE-SPECIFIC CARE

Effective July 1, 2005

[Revision: Updated standards references in Stroke Addendum to refer to current standard numbers.]

APPENDIX: PRIMARY STROKE CENTER CERTIFICATION

Primary Stroke Center Certification Program

The Joint Commission’s Primary Stroke Center Certification Program is based on the Recommendations for Primary Stroke Centers published by the Brain Attack Coalition and American Stroke Association statements for stroke to evaluate hospitals functioning as Primary Stroke Centers.

The on-site review team will include a health care professional with experience in treating stroke and implementing Primary Stroke Centers.

Eligibility

In addition to the eligibility requirements outlined in the *Disease-Specific Care Certification Manual*, programs seeking Primary Stroke Center Certification must use a standardized method of delivering clinical care based on the Brain Attack Coalition’s Recommendations for Primary Stroke Centers and guidelines developed by the American Heart Association/American Stroke Association (AHA/ASA) or equivalent evidence-based guidelines. Please refer to the AHA/ASA Web site for additional information (<http://www.americanheart.org/presenter.jhtml?identifier=3004586>).

Requirements

- Standards.** Hospital programs applying for Primary Stroke Center Certification will be evaluated using the standards listed in the *Disease-Specific Care Certification Manual*.
- Clinical Practice Guidelines.** The methods for evaluating compliance will include evaluating conformity with the Recommendations for Primary Stroke Centers, developed by the Brain Attack Coalition and published in the *Journal of the American Medical Association* (see pages 4–6 for additional information). In addition, hospitals will be expected to demonstrate their application of and compliance with the guidelines published by the AHA/ASA relevant to the stroke patient being treated.

- Performance Measures.** The ASA and the Joint Commission in addition to a jointly sponsored stroke advisory panel have reached consensus on a standardized set of performance measures for stroke. Disease-specific care (DSC) programs seeking certification are required to collect data on the first four measures of the standardized measure set (see below). Performance measure details are provided in the DSC Certification Program Performance Measurement Implementation Guide for Stroke.

Standardized Performance Measures for Stroke	
Set – Measure	Disease-Specific Care Performance Measure Name
Stroke-1*	DVT Prophylaxis
Stroke-2*	Discharged on Antithrombotics
Stroke-3*	Patients with Atrial Fibrillation Receiving Anticoagulation Therapy
Stroke-4*	Tissue Plasminogen Activator (t-PA) Considered
Stroke-5	Antithrombotic Medication Within 48 Hours of Hospitalization
Stroke-6	Lipid Profile
Stroke-7	Screen for Dysphagia
Stroke-8	Stroke Education
Stroke-9	Smoking Cessation
Stroke-10	A Plan for Rehabilitation Was Considered
* Required measures	
Note: All 10 measures comprise a set for pilot testing.	

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Updated Primary Stroke Center Appendix (continued)

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Appendix: Primary Stroke Center Certification (Continued)

Primary Stroke Center Certification		
Major Element	Brain Attack Coalition Recommendation	Joint Commission Expectation
1. Hospital and Administrative Support	<p>Organizational support and commitment from executive level administration shows designation of a stroke medical director and medical staffing by physicians with expertise in cerebrovascular disease.</p> <p>Written documentation from administration outlines the designation and authority of acute stroke teams.</p>	<p>Written documentation shows support of the Primary Stroke Center by hospital/health system administration. <u>PR.2, EP 2</u> <u>PR.1, EP 2</u></p> <p>A Primary Stroke Center medical director is appointed.¹ <u>PR.2, EP 1</u> <u>PR.1, EP 1</u></p> <p>Physicians on the acute stroke team have knowledge and expertise in the diagnosis and treatment of cerebrovascular disease. <u>PR.4, EP 1</u> <u>PR.3, EP 1</u></p>
2. Acute Stroke Team	<p>Written documentation indicates the following:</p> <ul style="list-style-type: none"> Stroke team composition Staffing level and requirements Stroke team notification system and response expectations <p>Stroke team logs document the following:</p> <ul style="list-style-type: none"> Response times Patient diagnosis Treatments and action Outcomes 	<p>Written documentation regarding stroke program operations delineates specific requirements and assignment of stroke team duties. <u>DF.1, EP 2</u></p> <p>Written documentation exists for stroke team notification system and expected response times.² <u>PR.4, EP 5</u> <u>PR.3, EP 5</u></p> <p>Evidence of stroke team log that captures stroke team response time to acute stroke patients, treatment used, and patient disposition. The log can be captured by written or electronic means and/or may be done retrospectively through chart audits. <u>CT.4, EP 3</u></p>
3. Written Care Protocols	<p>Written protocols include emergency care of patients with ischemic and hemorrhagic stroke, including stabilization of vital functions, initial diagnostic tests, and use of medication, including but not limited to r-PA treatment.</p>	<p>Protocols/care paths for the acute work-up of ischemic/hemorrhagic stroke patients are available in the emergency department (ED), acute care areas, and stroke unit (preprinted documents or electronically). <u>PR.11, EP 1</u> <u>PR.10, EP 1</u></p> <p>Use of the protocol is reflected in the order sets, pathways, or medical records. <u>DF.2, EP 4, EP 5</u></p> <p>Protocols demonstrate that the stroke center can provide FDA-approved treatments for stroke in accordance with indications and package inserts. (For example, for institutions that deliver thrombolytic therapy, r-PA protocol is available, with a three-hour window.)</p> <p>Protocol is de novo or adapted from extant resources and published guidelines. <u>DF.2, EP 1, EP 2</u></p> <p>Time parameters for stroke work-up are included in the protocol or the ED work-up protocol. <u>DF.2, EP 5</u> <u>EP 4; DF.3, EP 2</u></p> <p>For Primary Stroke Centers that treat and transfer acute stroke patients, written documentation includes time parameters and transfer procedures. <u>DF.2, EP 2</u></p> <p>Acute stroke protocols or order sets and pathways are included in the institution's routine process for review and updating. <u>DF.2, EP 6; DF.5, EP 2</u></p>

Appendix: Primary Stroke Center Certification *(Continued)*

Primary Stroke Center Certification		
Major Element	Brain Attack Coalition Recommendation	Joint Commission Expectation
4. Emergency Medical Systems	EMS/ED is integrated in the care and transport of stroke patients.	A description of the EMS is complete with any available treatment guidelines for pre-hospital personnel. Also, if available, include EMS stroke patient routing plans that address transferring stroke patients to stroke centers and stroke educational initiatives of the hospital for pre-hospital personnel. If these items are not available, a plan should be provided that demonstrates an initiative by the hospital to provide such with the EMS. <u>PR.7, EP 1, EP 2, EP 3</u> <u>PR.6, EP 1, EP 2, EP 3</u>
5. Emergency Department	ED care providers are familiar with the care of acute stroke patients, understand how to activate the stroke team, and use care pathways/protocols for acute stroke treatment.	ED care providers show familiarity with the following: <ul style="list-style-type: none"> The pathology, presentation, assessment, diagnostics, and treatment of patients with acute stroke The location and application of stroke-related protocols, activation of the acute stroke team, and communications with inbound EMS The recognition, assessment, and management of acute stroke complications <u>DF.1, EP 2</u> <u>EP 1, EP 5</u> Eighty percent of ED care providers can provide evidence of review of the institution's acute stroke protocol. The institution may choose how it will represent this evidence to the Joint Commission. <u>PR.4, EP 5</u> <u>PR.3, EP 5</u> ; <u>DF.1, EP 6</u> ; <u>DF.2, EP 9</u>
6. Stroke Units	Stroke units have the following: <ul style="list-style-type: none"> Trained staff Appropriate monitoring Stroke protocols (captured under "Written Care Protocols" section earlier in table) 	Note: <i>Stroke units can be defined and implemented in a variety of ways. The stroke unit does not have to be a specific enclosed area with beds designated only for acute stroke patients, but it will be a specified unit to which most stroke patients are admitted.</i> Care providers working in the stroke unit demonstrate evidence of initial and ongoing training in the care of acute stroke patients. They receive at least eight hours annually of continuing education or other equivalent educational activity, as determined appropriate by the stroke center director and as appropriate to the care providers' level of responsibility. <u>DF.1, EP 5, EP 7</u> Monitoring systems (as ordered) provide continuous data on the following physiologic parameters: <ul style="list-style-type: none"> Heart rate/rhythm with automatic arrhythmia detection Blood pressure with noninvasive blood pressure (BP) monitoring Oximetry <u>DF.2, EP 4</u> <u>EP 5</u>
7. Neurosurgical Services	Neurosurgical services are available within two hours of when it is deemed clinically necessary. If the hospital is providing neurosurgical care, operating room (OR) facilities are available in that facility.	Written documentation shows evidence of neurosurgical coverage or protocol for transfer to appropriate facility. <u>PR.4, EP 4</u> <u>PR.3, EP 1</u> ; <u>PR.5, EP 1</u> <i>For sites that do not transfer patients for neurosurgical emergencies, the stroke center has a fully functional OR facility and staff for neurosurgical services within two hours of the recognized need for such services.</i> <u>PR.4, EP 4</u> <u>PR.3, EP 1</u>
8. Neuroimaging	Obtain a diagnostic brain image ³ within 25 minutes of it being ordered, 24/7. Diagnostic image evaluated by qualified personnel within 20 minutes of completion, 24/7.	Documentation indicates that on a 24/7 basis, 80% of acute stroke patients have a diagnostic brain image (head CT) completed (and results reported to or reviewed by a member of the stroke team) within 45 minutes of it being ordered, when clinically indicated (in acute hemorrhagic or ischemic stroke resuscitation candidates). <u>PR.4, EP 4</u> <u>PR.3, EP 1</u> ; <u>PR.5, EP 1</u>

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Updated Primary Stroke Center Appendix (continued)

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Appendix: Primary Stroke Center Certification (Continued)

Primary Stroke Center Certification		
Major Element	Brain Attack Coalition Recommendation	Joint Commission Expectation
9. Laboratory Services	Laboratory services are available for initial stroke labs, 24/7. Laboratory service turnaround is less than 45 minutes. ECG and chest x-ray (as needed) are provided within 45 minutes.	Documentation indicates the ability to complete initial lab tests ⁴ and availability on site 24/7. PR.4, EP 4 PR.3, EP 1; PR.5, EP 1 Documentation indicates the ability to complete and report lab tests in less than 45 minutes from being ordered. PR.4, EP 4 PR.3, EP 1 Documentation indicates the ability to perform an ECG and chest x-ray within the same time frame as laboratory testing. PR.4, EP 4 PR.3, EP 1
10. Outcomes/ Quality Improvement	Stroke units have a method for tracking stroke performance. Quality improvement department and stroke team collaborate in on-going quality improvement efforts in stroke care.	Evidence of specific stroke performance measurement and review by quality improvement department and stroke team exists. PM.1, EP 1; PM.2, EP 3 EP 4, EP 5 Documentation exists to reflect the following: <ul style="list-style-type: none"> • Performance measures and indicators tracked PR.1, EP 2 PM.1, EP 2 • Specific interventions to improve in the selected measure PR.1, EP 3 PM.1, EP 3 • Specific outcomes to determine success PR.1, EP 3 PM.1, EP 3 • Implementation period and re-evaluation point PR.1, EP 3 PM.1, EP 3
11. Educational Programs	Stroke centers offer at least one public education event per year.	Documentation shows at least one stroke public education activity per year. SE.3, EP 5
Notes: <ol style="list-style-type: none"> 1. A stroke center medical director does not have to be a board certified neurologist; however, that would be the optimum condition. 2. Optimally, a care provider experienced in the diagnosis and treatment of stroke will be available within 15 minutes by telephone and at the bedside (as per a referring physician's request) of an acute stroke patient within the time period designated in the protocol and/or as instructed by the stroke center director. Response time adherence may also be accomplished through telemedicine and/or with a resident or other care provider in contact with an experienced stroke care provider within the time designated by the protocol. 3. The brain image can be obtained by CT or MRI and needs to definitively rule out/detect intra-cranial hemorrhage, or other causes of the stroke syndrome. The imaging needs to be available on site 24 hours a day/365 days a year (barring short term-failure, whereby the hospital should divert potential acute stroke patients). However, review of the images does not have to be done on site. Evaluation can be performed off site by telemedicine technology. 4. Lab tests include a complete blood cell count with platelet count, coagulation studies, (PT INR), and blood chemistries. DF.2, EP 4 		