Stroke Program: Concurrent Review Process
Developing an Organizational Process

Background:
Most often, data collection is retrospective. A retrospective review identifies patients receiving or not receiving therapeutic interventions. However, when patients do not receive therapeutic interventions are identified retrospectively, it is too late to impact their care. Concurrent data collection and monitoring facilitates quality care. The concurrent data collection and/or care monitoring process are resource intensive and require careful planning and implementation. To maximize the benefit for all patients, the concurrent review process should be a 24-hour, 7-day a week endeavor. Since the stroke coordinator doesn't work 24/7, they must enlist others in the concurrent review process. Tapping into existing documents and tools are helpful to minimize the impact on the work of others. It may require developing documents and processes as well.

The concurrent review process is the preferable method of collecting data and monitoring a patient's care. Concurrent review provides an opportunity to identify interventions not provided and change the care for the current patient. Additionally, it provides a trigger to ensure appropriate documentation is completed to accurately reflect that assessments were done and that the appropriate care is given. If the documentation is not completed, an addendum note should be completed by the appropriate provider.

Process:
The typical method of identifying patients for entry into the database is the retrospective coding process. Using the post-discharge coding results in a completely retrospective process. Using the appropriate suggestions below, as part of the concurrent review process, assists in identifying appropriate patients, while still hospitalized, providing an opportunity to improve the patient experience. Often coordinators elect to begin the data entry process as part of the concurrent review. However, the goals of a concurrent review are to identify patients not receiving appropriate interventions, find documentation not accurately reflecting the care provided, and generate a list of patients for entry into the database.

Select some processes that might work best for your facility from the suggestions below.

- Stroke activation codes: Request the ED nurse manager, ED staff nurse, the administrative supervisor, or the ED patient care assistant complete documentation of the stroke activation. Require the documentation be done by the end of the shift.

  Suggested methods:
  - Incident reports
  - Other department logs, documentation, or reports
  - Administration reports

- Emergency Department (ED) logbook: Request the ED nurse manager, ED staff nurse, the administrative supervisor, ED patient care assistant, or unit secretary complete documentation of the patient's chief complaint and the ED impression. Require the documentation be done by the end of the shift.

- The stroke coordinator, data abstractor, house nursing supervisor, or designee follows-up on all patients logged as having presenting symptoms/ED impressions for any of the following:

SUDDEN ONSET OF:

Stroke (include possible)	TIA (include possible)	Acute mental status change	Acute gait disturbance
Acute speech disturbance	Vertigo/Dizziness	Giddiness	Syncope
Diplopia	Expressive aphasia	Headache	Limb weakness
Fall with unknown reason	Numbness / Tingling	Possible seizure	Weakness

- Patient report completed by the ED nurse or provider by the end of the shift.
  - Administrative report
  - Incident/variance report

- Notification from ED/inpatient unit staff or provider to the stroke coordinator/designee.
  - Call. If no answer, request they leave a voice message.
  - Text message. Or other inhouse messaging system.

- Stroke coordinator/designee reviews a daily report of all neurology consults. Review the documentation to identify if the patient was or may be diagnosed as having a stroke or TIA.

- Rounding attended by the data abstractor/stroke coordinator/designee:
  - Once the patient is admitted, a stroke/TIA may be identified and discussed at Rounds
  - Ask questions re: diagnosis for patients with any identified "vague symptoms"

- Huddles attended by the data abstractor/stroke coordinator/designee. Same as Rounding.

- Database report: Run a daily Admission report.

- Pharmacy IV-Thrombolytic orders – Initiate a daily report.

- Telemedicine consults – Initiate a daily report and/or have an incident/variance report done.

Once documentation sources are initiated, the data abstractor and/or the stroke coordinator/designee are responsible to check minimally Monday – Friday, and follow-up as needed. The data abstractor/stroke coordinator/designee should follow-up on all patients identified. However, as part of the follow-up, others may be asked to participate. For example, documentation tools for "acute care" (ED care), "inpatient care," and "discharge care" (care provided on the patient unit) may be created. These tools can be triggers for the care to be done, or to facilitate appropriate documentation is completed. Using the staff on the unit to review for the care steps is preferable as it is a method of

reinforcing the recommended care. Using a checklist type inquiry is an easier and quicker method of monitoring the care. Once the checklist is completed, it is recommended the checklist be returned prior to the patient's discharge, if possible, to allow the providers the opportunity to provide the necessary care/interventions.

Alternatives to the patient's assigned nurse completing the checklist are:
- ED/unit nurse manager
- Case managers
- Quality staff
- Concurrent coding staff

Creating the Tools:
- Using the GWTG-Stroke, identify the acute, inpatient, and discharge measures for entry.
- Using the GWTG-Stroke entries, make a separate sheet for the 3 areas of care. An area for entering the time done and checking or other method of indicating the care was completed. Be specific regarding if a time, or check is required.

In using the GWTG-Stroke entries to develop the tool, be sure to use ONLY those measures that reflects that care provided by the nurse and the physician, nurse practitioner or physician assistant. Do not use all the data points on the tool. Remember, the goals for the current review process are to identify patients not receiving appropriate interventions and find documentation not accurately reflecting the care provided and generate a list of patients for entry into the database. The purpose is not to collect data.