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TELESTROKE REFERRING SITE APPLICATION

The purpose of this documentation is to record a site's readiness and need in participating in the Ontario Provincial Telestroke Program as a referring site.
This application should be completed in conjunction with your Regional/District Stroke Centre

Section	Name	Description
A	Requesting Organization Information	General contact information
B	Readiness	To determine administrative, financial & technical readiness for telestroke.
C	Clinical Profile	To determine level of clinical preparedness for telestroke.
D	Post Telestroke Care	To determine how best practice stroke care will be provided post tPA administration.

A: REQUESTING ORGANIZATION INFORMATION

Organization Name: _____

Site: _____ Facility Number: _____

Full mailing Address: _____

LHIN#: _____ Stroke Region: _____

Primary Contact Person Name: _____

Title: _____

Phone: _____ Fax: _____ Email: _____

Telemedicine Coordinator Name (if applicable): _____

Phone: _____ Email: _____

Technical Contact Name (if applicable): _____

Phone: _____ Email: _____

Site Status: ☐ Existing Member OTN Site # (if known) _____ ☐ New Site

Anticipated Telestroke Model: ☐ 24/7 ☐ PRN ☐ Set Schedule

Telestroke Model Definitions:

24/7 - Referring site physicians rely on Telestroke to delivery tPA 24 hrs./day, 7 days per week

PRN - Not all the referring site physicians require the use of Telestroke to deliver tPA; Telestroke is used when required

Set Schedule - Referring site has a set schedule where Telestroke is required to ensure coverage for tPA delivery (e.g. Mon thru Friday you do not use Telestroke, but required on weekends)

B: READINESS

HUMAN RESOURCES

ED physicians/internists willing to participate? ☐ Yes ☐ No
Are they willing to be available for telestroke 365 days/year? ☐ Yes ☐ No

Additional comments?

Emergency Department MAC Chair supports telestroke application: ☐ Yes ☐ No _____ *(name)*

Emergency Administrative Director supports telestroke application: ☐ Yes ☐ No _____ *(name)*

CT Techs available 24/7? ☐ Yes ☐ No

Additional comments?

LEADERSHIP

Endorsement by hospital administration/senior management team/ MAC to move a telestroke initiative forward? ☐ Yes ☐ No

Organization telestroke point of contact/liaison identified: ☐ Yes ☐ No _____ *(name)*

Designated physician champion: _____ *(name)* ☐ Yes ☐ No

Designated leadership champion: _____ *(name)* ☐ Yes ☐ No

Designated clinical staff champion: _____ *(name)* ☐ Yes ☐ No

Regional Stroke Steering Committee and/or District Stroke Steering Committee Letter of Support enclosed? ☐ Yes ☐ No

LHIN CEO support/approval; letter of support enclosed ☐ Yes ☐ No

ADMINISTRATIVE

Agreement, in principle, to participate in data collection activities? ☐ Yes ☐ No

FINANCIAL

Funding available for training of all relevant personnel (e.g. MDs, RNs, ED staff, tech support, DI)? ☐ Yes ☐ No ☐ In development

Funding for OTN network drops in ED? ☐ Yes ☐ No

Funding for telemedicine equipment? ☐ Yes ☐ No

Comments: ☐ N/A *(e.g. equipment available)*

TRAINING

Commitment to undergo clinical training and collaboration with Regional Stroke Centre re. stroke and tPA administration in ED? ☐ Yes ☐ No

Commitment to undergo training of telemedicine technology and telestroke processes in ED with the Ontario Telemedicine Network? ☐ Yes ☐ No

TECHNICAL

Is there any existing telemedicine equipment available for use in the Emergency Department? ☐ Yes ☐ No

System Type: ☐ Cisco ☐ Polycom Specify equipment model _____ *(please identify)*

Willing to comply with "OTN Standard Telestroke Equipment" and configuration? ☐ Yes ☐ No

Willing to accommodate network infrastructure changes as required? ☐ Yes ☐ No

Does your CT Scanner currently push CT heads to ENITS? ☐ Yes ☐ No

Have you implemented the CT/mCTA protocol with ENITS? If no, describe plans to address. ☐ Yes ☐ No

Do you have an MRI? ☐ Yes ☐ No

If yes, does your MRI push to ENITS? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Please provide any other relevant information:

C: CLINICAL OPPORTUNITY/PROFILE

STROKE STATISTICS

Approx. # of stroke patients per year (if known): _____

Is tPA currently administered on site? ☐ Yes ☐ No

DISTANCE FROM

Closest Regional or District Stroke Centre_____ km Name of Regional or District Stroke Centre_____

NEUROIMAGING

CT scanner available 24/7? ☐ Yes ☐ No

-CTA available 24/7? ☐ Yes ☐ No

CT technician on-site 24/7? ☐ Yes ☐ No

-CT technician on-site able to do CTA 24/7? ☐ Yes ☐ No

Comments

PATIENT MODEL TO BE DEVELOPED

☐ Drip and keep patient post tPA ☐ Drip and ship patient post tPA

CLINICAL PROTOCOLS

Note – protocols listed as 'in development' must be completed and submitted for approval prior to a site going live with telestroke services.

Commitment to participate in the regional medical redirect, if applicable? Please indicate if in development.

☐ Yes ☐ In development: _____ *Anticipated date of completion*

☐ No

If yes, please indicate - With or to?

Approved clinical telestroke protocol for tPA administration and monitoring in ED:

☐ Yes ☐ In development: _____ *Anticipated date of completion*

☐ No

Triage process developed for access into ED within 10 minutes or less, 24/7:

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

Triage protocol (Code Stroke) established and documented:

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

Process for STAT CT/mCTA 24/7 (target door to CT 15 minutes):

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

Protocol for acute ischemic stroke tPA administration in accordance with best practice guidelines established:

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

STAT Lab services and communication of results processes established 24/7:

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

Pharmacy preparedness for t-PA based on projected volumes (e.g. stock/supplies, distribution, budget):

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

Development of t-PA administration protocol including post infusion care (24 hours):

☐ Yes ☐ In development: _____
Anticipated date of completion

☐ No

D: POST tPA CARE

STROKE UNIT CARE

Stroke Unit on Site ☐ Yes ☐ No ☐ In development

If yes, describe stroke unit model, # of beds, staffing model/complement/existing care pathways/protocols, monitored beds.
(A stroke unit is defined as a geographical unit with identifiable co-located beds (e.g., 5A-7, 5A-8, 5A-9, 5A-10) that are occupied by stroke patients 75% of the time and have a dedicated inter-professional team with expertise in stroke care including, at a minimum, nursing, physiotherapy, occupational therapy and speech-language pathology.)

Development of plans to manage acute stroke inpatients based on best practice guidelines:
☐ Yes ☐ In development Anticipated completion date
☐ No

Development of transfer protocol to stroke unit: ☐ Yes ☐ No ☐ In development

Please describe transfer protocol:

ADDITIONAL COMMENTS

SIGNATURES

Physician Champion	_____ *Signature*	_____ *Date*
Leadership Champion	_____ *Signature*	_____ *Date*
Clinical Staff Champion	_____ *Signature*	_____ *Date*
Emergency Department Chair	_____ *Signature*	_____ *Date*
Emergency Program Director	_____ *Signature*	_____ *Date*
Regional Program/ District Stroke Director	_____ *Signature*	_____ *Date*