

ANGELS REGIONAL ACTION PLAN

Date ___/___/___



1. REGION INFORMATION

Name

Population

Estimated # of strokes p.a.

Stroke ready hospitals needed

Stroke ready hospitals currently

Comprehensive centers needed

Comprehensive centers currently

2. ANGELS REGIONAL WORKING GROUP

Regional coordinator of stroke network _____

EMS regional coordinator _____

Regional coordinator of quality monitoring _____

Nurse representative _____

Patient association representative _____

Rehabilitation representative _____

Neuroradiologist representative _____

Other Members _____



4. LIST OF HOSPITALS

	HOSPITAL	ANGELS REGISTERED	AWARD STATUS	SIMULATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

5. GOALS

A. Number of hospitals in Angels

Current number of hospitals

Target number of hospitals for this year

B. Number of hospitals with at least Gold Status

Current number of hospitals

Target number of hospitals for this year

C. Regional protocols in place for...

Pre-hospital

In place

Not in place

Referrals Stroke NetworkProtocol

In place

Not in place

Hub-spoke Transfer Checklist

In place

Not in place

D. Network development (ideas, plans and examples)

E. Quality Monitoring

SITS

RESQ

National Registry

EMS Registry

Quality Monitoring Action Plan: (needs of the region, proposal and plan)

6. EVENTS AND TRAININGS PLAN

A. Simulation Trainings

Current number	<input type="text"/>	Target number	<input type="text"/>
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B. EMS Workshops

Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>

C. Nurse Workshops

Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>

D. Hub- Spoke EVT Network Workshops

Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>

E. _____ Workshops

Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>
Date	<input type="text"/>	City	<input type="text"/>	Main Person	<input type="text"/>

ACTION PLAN AGREED AND APPROVED BY:

Name _____ Signature _____

Signature _____

