APPENDIX: 13

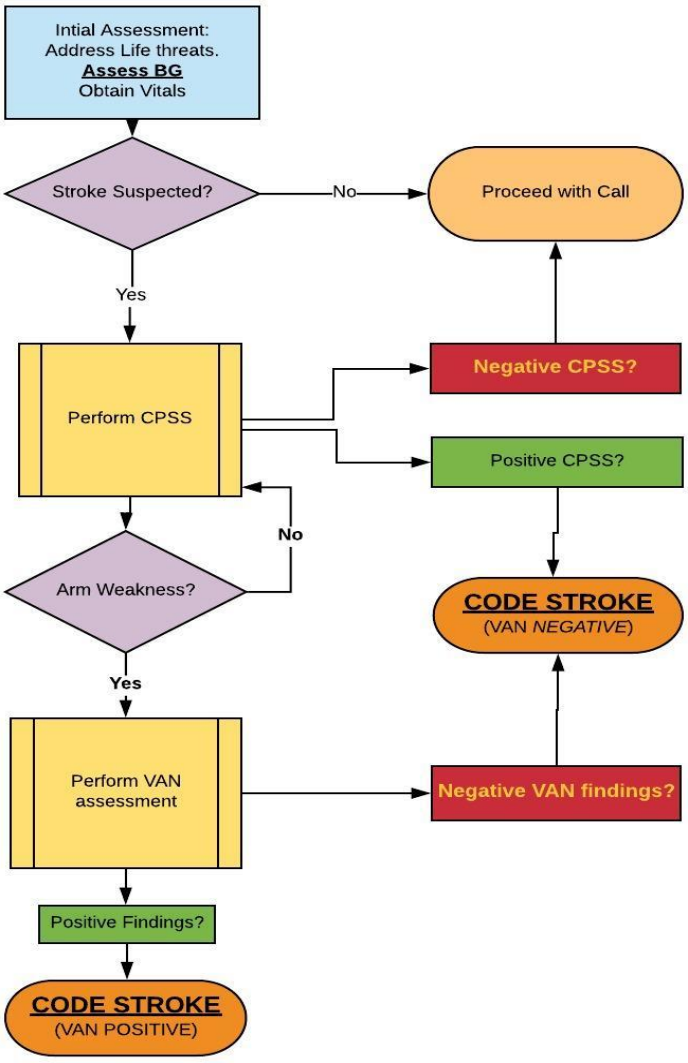
TITLE: Stroke Assessment

Updated: November 1, 2018

General Comments: The purpose of this procedure is to standardize the minimum assessment of suspected stroke patients**. This assessment should combine the use of the VAN and Cincinnati Stroke assessments.** Providers may add other assessments as appropriate.

Procedure:

In the ACCESS system, there are two substantial types of stroke centers. Level I (Comprehensive) Stroke centers that can provide direct resolution of clots in Large Vessel Occlusion (ELVO) strokes, and Level 2 (primary) stroke centers that may provide thrombolytic therapy ("clot Busting Agents") for other kinds of strokes.
ACCESS providers will use stroke assessments to facilitate choosing the most appropriate destination in accordance with the hospital destination protocol.



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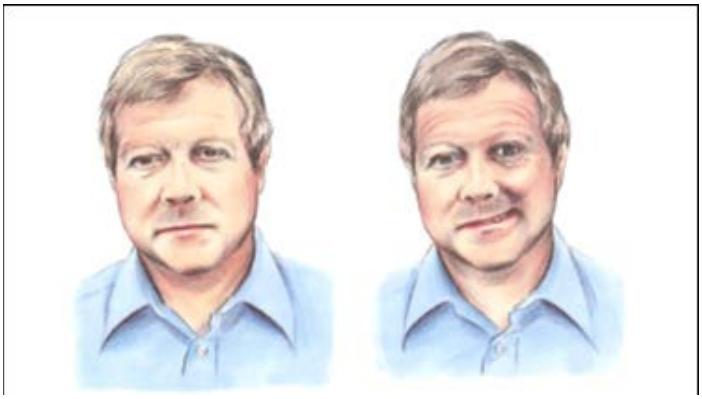
The Cincinnati Prehospital Stoke Scale: THINK F.A.S.T.

F: Facial Droop (Have the patient show teeth or smile):

- Normal – both sides of face move equally
- Abnormal – one side of face does not move as well as the other.



Left: Normal, Right: Stroke patient with facial droop (right side of face)

A: Arm Drift (Patient closes eyes and extends both arms straight out, with palms up, for 10 seconds):

- Normal – both arms move the same or both arms do not move at all (other findings, such as pronator drift, may be helpful)
- Abnormal – one arm does not move or one arm drifts down compared with the other

S: Abnormal Speech (Have the patient say "you can't teach an old dog new tricks"):

- Normal – patient uses correct word with not slurring
- Abnormal – patient slurs words, uses the wrong words, or is unable to speak

Interpretation: If any 1 of these 3 signs is abnormal, the probability of a stoke is 72%

T: Time

Determine "Last known well" and time of onset.

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The VAN stroke assessment:

The VAN assessment is typically performed AFTER other stroke assessments. Patient must have arm weakness ***AND*** a deficit in the VAN assessment to be considered VAN positive. A VAN negative patient should still be assessed using the Cincinnati stroke scale or other stroke assessments.

Large Artery Stroke Screening Forms for VAN

1. How weak is patient on one side of body?

- ☐ *Mild* (minor drift) (hold both arms up for 10 seconds) **PROCEED WITH VAN EXAM.**
- ☐ *Moderate* (severe drift - touches or nearly touches ground) **PROCEED WITH VAN EXAM.**
- ☐ *Severe* (flaccid or no antigravity) **PROCEED WITH VAN EXAM.**
- ☐ Patient shows no weakness. **Patient is VAN negative. Proceed to other stroke assessments.**

(exceptions are confused or comatose patient's with dizziness, focal findings or no reason for their altered mental status then Basilar artery thrombus must be considered)

2. Visual Disturbance?

- ☐ *Field Cut:* Peripheral Vison and Eye Movement (4 quadrants) ("How many fingers am I holding up")
- ☐ Double vision (ask patient and look to right then left, evaluate for uneven eyes)
- ☐ Blind new onset
- ☐ NONE

3. Aphasia?

- ☐ Expressive (inability to speak or errors) don't count slurring of words (repeat & name 2 objects)
- ☐ Receptive (not understanding or following commands) (close eyes, make fist)
- ☐ Mixed
- ☐ NONE

4. Neglect?

- ☐ Forced gaze or inability to track to one side
- ☐ Unable to feel both sides at same time, or unable to identify own arm
- ☐ Ignoring one side
- ☐ NONE

If patient has **any** arm weakness (step 1) **PLUS** any abnormal findings in the VAN exam, the patient is considered VAN POSITIVE. This is likely a large artery clot (cortical symptoms).

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Physician Pearls:

Below is the AHA/ASA recommended goals for management of stroke. This does not supersede the ACCESS SWO and protocols.