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Pre-hospital care concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for pre-hospital staff. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, pre-hospital staff should consider the guideline in full.

Overall organisation of acute stroke services

2.2.1A Community medical services and ambulance services (including call handlers and primary care reception staff) should be trained to recognise people with symptoms indicating an acute stroke as an emergency requiring transfer to a hyperacute stroke centre.

Specialist stroke services

2.3.1A People seen by community-based clinicians (e.g. ambulance paramedics) with the sudden onset of focal neurological symptoms should be screened for hypoglycaemia with a capillary blood glucose, and for stroke or TIA using a validated tool. Those people with persisting neurological symptoms who screen positive using a validated tool should be transferred to a hyperacute stroke unit as soon as possible.

2.3.1B People with suspected acute stroke (including when occurring in people already in hospital) should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist physician without delay.

2.3.1.G Acute stroke services should ensure that people with conditions that mimic stroke are transferred without delay into a care pathway appropriate to their diagnosis.

2.3.1.J Acute stroke services should have an education programme for all staff providing acute stroke care (including ambulance services and the emergency department as appropriate) and should provide training for healthcare professionals in the specialty of stroke.

2.3.1.K Acute stroke services should participate in national and local audit, multi-centre research and quality improvement programmes.

Pre-hospital care

3.1.1B People who are negative when screened with a validated tool but in whom stroke is still suspected should be treated as if they have stroke until the diagnosis has been excluded by a specialist stroke clinician.

3.1.1C The pre-hospital care of people with suspected stroke should minimise time from call to arrival at hospital and should include a hospital pre-alert to expedite specialist assessment and treatment.

3.1.1D Patients with suspected stroke whose airway is considered at risk should be managed appropriately with suction, positioning and airway adjuncts.

3.1.1E Patients with residual neurological symptoms or signs should remain nil by mouth until screened for dysphagia by a specifically trained healthcare professional.

3.1.1F Patients with suspected TIA should be given 300mg of aspirin immediately and assessed urgently within 24 hours by a specialist physician in a neurovascular clinic or an acute stroke unit.

3.1.1G Patients with suspected stroke or TIA should be monitored for atrial fibrillation and other arrhythmias.

Management of TIA - assessment and diagnosis

3.2.1A Patients with acute neurological symptoms that resolve completely within 24 hours (i.e. suspected TIA) should be given aspirin 300 mg immediately and assessed urgently within 24 hours by a specialist physician in a neurovascular clinic or an acute stroke unit.

3.2.1B Patients with suspected TIA that occurred more than a week previously should be assessed by a specialist physician as soon as possible within 7 days.

3.2.1C Patients with suspected TIA and their family/carers should receive information about the recognition of stroke symptoms and the action to be taken if they occur.

Commissioning acute stroke services

6.2.1A Ambulance services, including call handlers, should be commissioned to respond to every person with a suspected acute stroke as a medical emergency.

6.2.1B Commissioners should commission acute stroke services in accordance with the recommendations in this guideline to provide:

> urgent brain imaging for patients with suspected acute stroke;

> treatment with alteplase for patients with acute ischaemic stroke;

> an endovascular service for patients with acute ischaemic stroke;

> a neuroscience service to admit, investigate and manage patients referred with subarachnoid haemorrhage, both surgically and with interventional radiology;

> a neuroscience service delivering neurosurgical interventions for intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus;

> direct admission of patients with acute stroke to a hyperacute stroke unit providing active management of physiological status and homeostasis within 4 hours of arrival at hospital;

> an acute neurovascular service for the diagnosis and treatment of people with suspected TIA;

> an acute vascular surgical service to investigate and manage patients with TIA and non-disabling stroke due to carotid artery stenosis.

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Setting higher standards

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