

Stroke Video Triage Newsletter



107

251

358

Video Triages undertaken in
North Cambridgeshire

Video Triages undertaken
in North Cambridgeshire

Total video triages
undertaken

Welcome to the third edition of The Stroke Video Triage Newsletter. In this edition,
A few updates to start with:

Stroke video triage audit: As part of our continuous efforts to ensure as many patients within our pilot regions benefit from stroke video triage, we will be reviewing patients who presented as a stroke within the pilot areas to identify those patients who are not video triaged. This is to identify any barriers ambulance clinicians are facing which prevents utilising the pathway. If it's not clear from the EPCR why video triage wasn't used (i.e. connectivity wouldn't allow or patient refused) then we will follow up with the crew to establish any barriers / perceived barriers.

Expansion update: In collaboration with the South Integrated Stroke Delivery Network, we have now submitted a bid to NHS England for further funding, to support expansion of Stroke Video Triage to a further five acute stroke centres. We are also currently working with two further hospitals in the North Integrated Stroke Delivery Network, who are looking to implement in the near future. If our current expansion plans are successful, over 50% of the hospitals within East of England will be participating in stroke video triage. As part of a multidisciplinary approach, some of our video triage services may include specialist stroke nurses undertaking video triage. We expect to find out later this month (August) whether our bid was successful and will of course update you in the next issue of our newsletter.

Stroke Video Triage training: The training package is located on your iPads under "stroke video triage training". Any questions or issues please email Andrew.Larby@eastamb.nhs.uk

Stroke Training: Monthly CPD training is being setup for stroke across the East of England region, keep an eye on Need to Know for details on how to join.

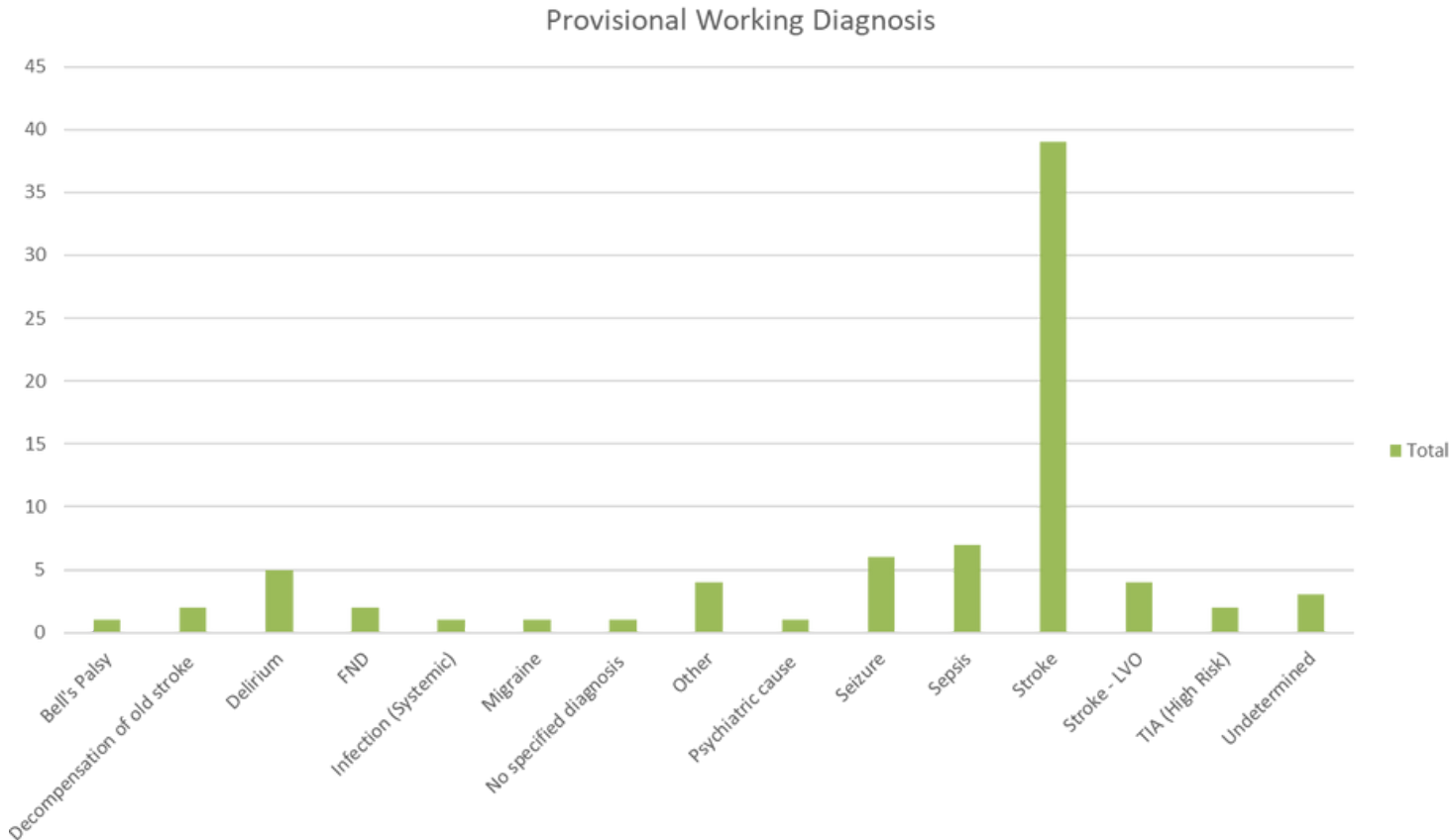
Patient Final Diagnosis:

Every patient who is video triaged is reviewed in our clinical case reviews. During these case reviews we review the EPCR (Electronic Patient Care Record) and their notes during their episode of care in the Emergency Department and if applicable whilst admitted to the ward. The final diagnosis is for the patient is then determined, and compared to the provisional diagnosis documented by the video triage clinician. This enables us to calculate the diagnostic accuracy of stroke video triage and compare it to other tools used in the pre-hospital environment.

Whilst majority of the patient's video triaged do turn out to be having Strokes, a significant number do in fact turn out to be stroke mimics, and have not in fact had a Stroke.

Below is an audit carried out in April 2023, which showed the top 3 diagnoses behind Stroke are Sepsis, Seizures and Delirium.

This shows the importance of video triage, we looked in our last newsletter at the diagnostic accuracy, which is demonstrated to be superior to FAST. FAST whilst is a highly effective tool for predicting Stroke, the tool does not exclude patients who are having our top 3 causes of mimics.



Case Study 1

Patient: 62 year old female, ? TIA(details pseudonymised to protect confidentiality)

PMH: Dementia & Epilepsy

History: Patient noticed her left eye was drooping and left facial droop. Called 999 immediately as thought she was having a Stroke. Crew arrived on scene within 40 minutes.

Dhx: Medicated for Epilepsy. No anti-coagulants

On Examination:

DRCABC: No concerns.

FAST: FAST -ve. Symptoms fully resolved.

Obs: All within normal limits

Crew impression: Patients symptoms have fully resolved, currently asymptomatic. Crew contacted Stroke Video Triage. Carried out NIHSS score = 0. Referred to TIA clinic for follow up. Crew advised to administrator 300mg Aspirin as per JRCALC.

Outcome: Followed up in TIA clinic, imaging normal, unable to rule out TIA. Secondary prevention commenced on daily aspirin.

Transient Ischaemic Attack (TIA / 'Mini Stroke')

What is Transient Ischaemic Attack (TIA)?

TIA is a transient (less than 24 hours) neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia, without evidence of acute infarction. A TIA has a sudden onset and can last from a few minutes to 24 hours. Most people have complete resolution of symptoms and signs within 1 hour.

How is TIA assessed?

A TIA will present in the same way as a Stroke, and a TIA can only be determined when the symptoms have fully resolved within 24 hours of symptom onset. A patient cannot be determined as a TIA until the symptoms have fully resolved, even if symptoms are resolving during assessment.

How is a TIA managed?

If an ambulance crew attend a patient who has had stroke symptoms, which have fully resolved within 24 hours of onset, and is presenting as a likely TIA, should be video triaged where it is available and you are assessing the patient during the hours of operation. If Stroke Video Triage is not available, the patient should be taken to the nearest Emergency Department for further assessment.

On video triage, if the video triage clinician agrees symptoms have fully resolved following their assessment, the patient should be offered 300mg aspirin (unless contraindicated). The patient should be referred for specialist assessment and investigation, to be seen within 24 hours of onset of symptoms. Scoring systems such as ABCD2 should not be used to assess risk of subsequent stroke. Certain presentations, such as crescendo TIA's, may still require urgent further assessment at their nearest emergency department.