STROKE ADMISSION PATHWAY

On arrival at ED all suspected Stroke Patients will follow this pathway.

1. Triage nurse will carry out Rosier Scale Stroke Assessment

2. If Rosier scale is greater than 0 - acute stroke is likely. Medical review should be requested and bed management informed in order to facilitate bed. ED doctor to discuss directly with Stroke Consultant (in hours) or Medical Receiving Doctor (out of hours)

3. In hours – CT scan to be requested immediately following discussion with Radiologist. Out of hours (required immediately) should be discussed with the on call Radiologist. Out of hours (required within 24 hours) request will be made by the inpatient team. Patients who have CT carried out whilst still in the ED will remain in the ED until scan result available.

4. Diagnosis of stroke will be made following medical review of CT scan and/or clinical presentation. Patient to be transferred to Stroke Unit if bed available.

5. If stroke bed not available patient will be transferred to J North. Stroke Liaison Nurse will be informed via bed management and follow up in the morning (Monday – Friday)

On admission to ward:-

1. Swallow assessment to be carried out immediately. If N.B.M urgent referral to S.A.L.T should be requested and documented in nursing notes.

2. When C.T results available, where appropriate, secondary prevention initiated and documented in case notes.

THANK YOU
THE STROKE TEAM.

Stroke Admission Pathway