

**Stroke Services BC**  
**Position Statement: FAST VAN**

**Date of Decision: April 16, 2026**

**Anticipated Date of Review: Spring 2028**

**Topic:** Screening for acute stroke

**Summary of Recommendation:** All BCEHS paramedics will use FAST VAN as the standardized pre-hospital stroke screening tool. FAST VAN will also be used by nurses and other clinicians in the in-hospital setting to screen for acute stroke.

**Context for Change:**

In 2017, FAST VAN was introduced as the provincial pre-hospital stroke screening tool in response to the inconsistent use of screening tools across BC and the emerging role of endovascular therapy. Since then, FAST VAN has been used informally in hospitals by emergency and inpatient nurses, but without consistency or standardized education. This highlights the need for a coordinated provincial approach and formal nurse training and education.

**Description:**

FAST (Face, Arm, Speech, Time) was the original paramedic screening tool. In 2017, VAN (Vision, Aphasia, Neglect) was added to improve identification of large vessel occlusions and guide transport decisions. BCEHS implemented education at that time to support this change. In 2020, FAST VAN was incorporated into the Triage and Transport Guideline, which outlined screening, pre-hospital notification, and transport decision-making. In 2024, BCEHS updated practice expectations: paramedics are now required to complete both FAST and VAN for all suspected stroke patients, regardless of FAST results. This was formalized in the 2025 Triage and Transport Guideline update.

In hospital, FAST VAN has since been adopted in many regions across the province for stroke screening in emergency and triage, as well as inpatient settings as part of in-hospital hot stroke protocols. A provincial standardized approach for in-hospital use of FAST VAN will support clear communication between paramedics and emergency departments, improve information sharing among hospital teams (including inpatient units, rapid response teams, and physicians), and ensure a consistent stroke screening process across all hospital settings, while also providing an opportunity to support nurse-specific education and training on FAST VAN.

Note: in line with the CSBPR's, in-hospital is defined as a person admitted to an inpatient unit, the emergency department, or outpatient clinic in a hospital setting.

### **Evidence:**

The Canadian Stroke Best Practice Recommendations recommend that “EHS personnel should use a standardized acute stroke out-of-hospital diagnostic screening tool as part of on-scene assessment” in addition, in the emergency department patients “should have a rapid neurological examination to determine focal neurological deficits using a validated scale such as FAST (Face, Arm, Speech, Time); and to assess for stroke severity using a validated screen ([www.strokebestpractices.ca](http://www.strokebestpractices.ca)). FAST has been used as a pre-hospital screen for some time and is favoured for its relative simplicity and ease of assessment. The addition of VAN can help to identify patients most likely to be having a large-vessel occlusion<sup>1</sup>, which can inform decision making about transport and team assembly to reduce time to treatment.

### **Considerations:**

The use of FAST VAN in the in-hospital setting should be supported with education and protocols to support Code Stroke/Hot Stroke for suspected in-hospital stroke. Specific protocols should be determined at the site and regional level.

In the in-hospital setting, it is reasonable to broaden certain screening elements beyond those used in the BCEHS FAST VAN assessment. For in-hospital stroke, testing visual fields in addition to assessing gaze deviation as part of the vision screen, as well as expanded definitions for assessing aphasia and neglect is reasonable in this setting. Clinicians performing these assessments should receive additional training and education, and treating physicians should recognize that there may be variability in the reliability of these more advanced assessments.

Treatment for disabling stroke symptoms with LVO may be considered up to 24hrs from symptom onset or last seen normal. Patients expected to benefit from extended window treatments would have one or more of the following symptoms:

- Disabling weakness
- Aphasia (not slurred speech)
- Neglect
- Gaze deviation
- Visual field cut (not monocular vision loss)

These patients also require advanced imaging and Neurology consult.

---

<sup>1</sup> Taleb et al (2016). Stroke Vision, Aphasia, Neglect (VAN) assessment – a novel emergent large vessel occlusion screening tool: pilot study and comparison with current clinical severity indices. *Journal of Neurointerventional Surgery*. Published online on 17 Feb 2016. Available at <http://jn.is.bmj.com>.

**Approved By:**

- SSBC Clinical Advisory Group
- SSBC Executive Stroke Steering Committee

**For questions, please contact:**

Alison de Wit, Clinical Nurse Specialist, Stroke Services BC, [alison.dewit@phsa.ca](mailto:alison.dewit@phsa.ca)

Kimia Ghavami, Stroke Neurologist & Acute Medical Lead Stroke Services BC,

[Kimia.ghavami@vch.ca](mailto:Kimia.ghavami@vch.ca)