Stroke/Suspected Stroke – Supplemental Protocol

This protocol is a supplement to the **Stroke/Suspected Stroke Protocol** (3-2) and contains additional assessment and treatment guidelines for STMCA providers.

1. Follow **General Pre-hospital Care Protocol**.
2. Assessment and History - If the patient presents with a new onset neurological complaint, screen for stroke by completing the first components of the FAST-ED assessment:

FACE

		Score
Does the patient have facial weakness?	**Normal** (both sides of face move equally)	0
	Abnormal (one side of face droops or is asymmetrical)	1

ARM

Does the patient have arm weakness? (If patient cannot understand hold his/her arms up and then let them go)	**No drift** (Both arms remain up > 10 seconds or slowly drift equally)	0
	Drift or some effort against gravity (One arm drifts down in < 10 seconds but has antigravity strength)	1
	No effort against gravity or no movement (One or both arms fall rapidly, have strength against gravity)	2

SPEECH OUTPUT

Check speech content & ask the patient to name 3 common items (If speech is slurred but makes sense and naming is correct score as normal)	**Normal** (Speech content normal AND names 2-3 items correctly)	0
	Abnormal (Speech Content clearly abnormal OR names only 0-1 items clorrectly)	1

SPEECH COMPREHENSION

Ask the patient: "Show me two fingers"	**Normal** (Patient shows two fingers)	0
	Abnormal (Patient cannot understand/does not show two fingers)	1

Note: If facial palsy, arm weakness, and speech changes indicative of stroke are absent, end the stroke assessment and continue with **Patient Assessment Protocol**. If signs and symptoms of stroke are identified, score the severity of the deficit(s) noted according to the FAST-ED stroke severity scale and continue the stroke assessment by completing the remaining components, listed below. Ensure you document all FAST-ED assessment scores, when applicable.

EYE DEVIATION

		Score
Does the patient have gaze deviation to either side? (Some patients will follow your face better than your finger)	**Normal** (No deviation, eyes move to both sides equally)	0
	Gaze preference (Patient has clear difficulty when looking to one side (left or right)	1
	Forced deviation (Eyes are deviated to one side and do not move to the other side)	2

DENIAL/NEGLECT

Ask the Patient: "Are you weak anywhere?" and "Whose arm is this?"	**Normal** (Patient recognizes they are weak and recognizes the arm)	0
	Can either recognize weakness or own arm but not both	1
	Does not recognize own arm and cannot identify weakness	2

Total Score: _____

a. Notify the receiving facility as soon as possible once the initial FAST-ED is performed.
b. If there are witnesses of the onset; have them accompany the patient to the hospital if at all possible.
    i. Gather as much pertinent past medical history information as possible without delaying scene time.
    ii. Medications; especially anticoagulant or diabetic related therapies
    iii. Past intracranial surgery or serious head trauma within the past 3 months
    iv. Previous transient ischemic attacks
    v. History of internal hemorrhage (GI, aneurysm, etc.)

3. Transport
    a. Minimize scene time. Do not delay for IV starts or other treatment.
4. Destination
    a. Patients with positive stroke screen and/or a strong suspicion of stroke should be transported rapidly to the closest healthcare facility that can administer IV alteplase.
    b. Exception: A patent airway cannot be established.(patient may be transported to the closest receiving hospital):
5. Radio Reporting
    a. Contact the receiving facility as soon as possible and identify the patient as a “STROKE ALERT”. Goal is 5 minutes from initial patient contact.
    b. Provide the following information either initially or while enroute:
        i. FAST-ED score and list the neuro deficits identified.
        ii. Last-know-well date and time
        iii. Date and time of symptom discovery
        iv. Blood thinner usage (name and time of last dosage)
6. Inter-facility Management of Acute Ischemic Stroke Patients
    a. Document vital signs prior to transport and verify SBP is less than 220 mmHg (180 mmHg if treatment with IV tPA). If SBP is above limits, sending facility should stabilize prior to transport.
    b. Perform and document initial neurological exam and note any changes during transport.
    c. Provide continuous cardiac monitoring.
    d. Contact medical control if hemodynamically unstable or symptoms arise due to tachycardia or bradycardia.