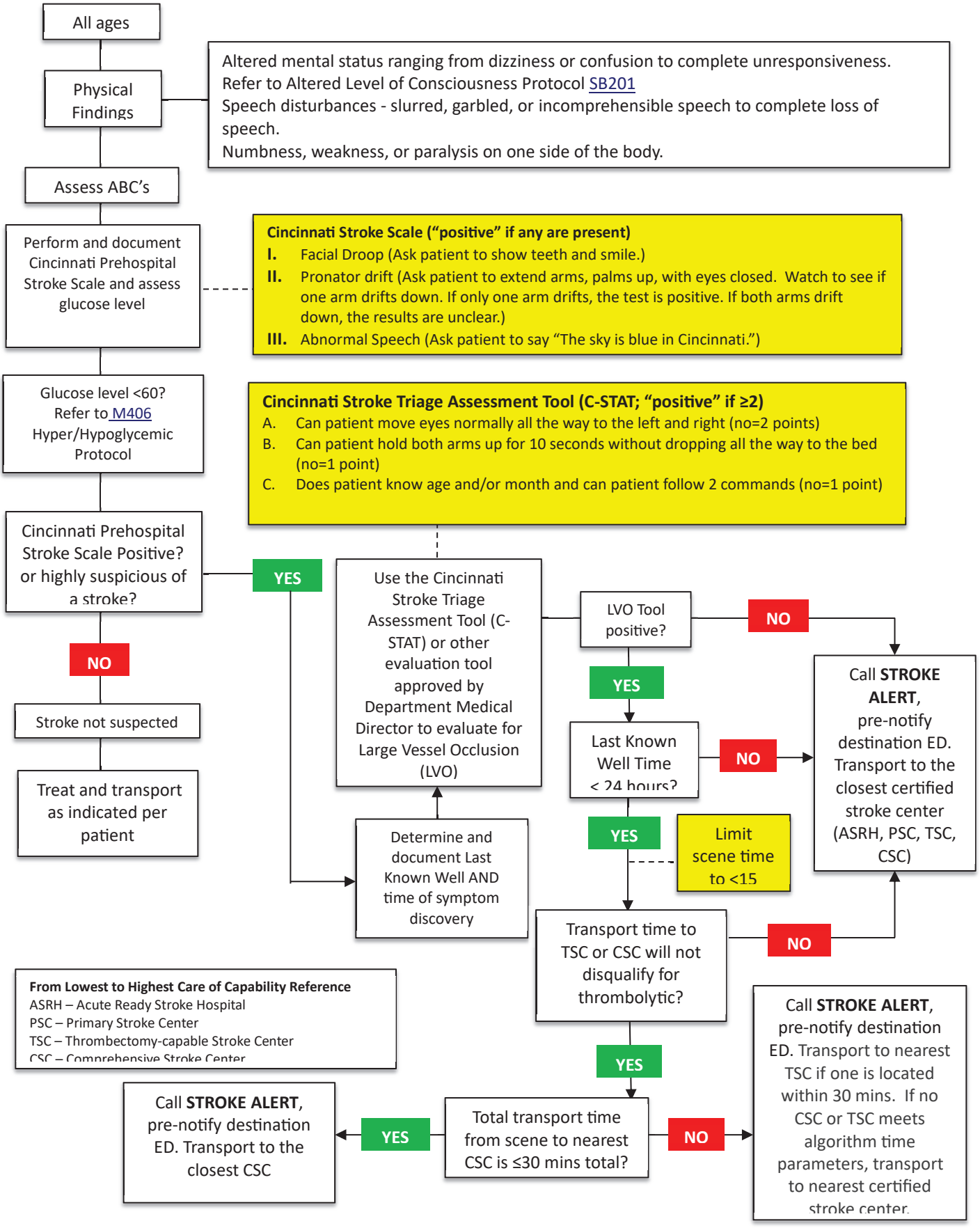

All ages
Physical Findings
Altered mental status ranging from dizziness or confusion to complete unresponsiveness. Refer to Altered Level of Consciousness Protocol SB201
Speech disturbances - slurred, garbled, or incomprehensible speech to complete loss of speech.
Numbness, weakness, or paralysis on one side of the body.
Assess ABC's
Perform and document Cincinnati Prehospital Stroke Scale and assess glucose level
Cincinnati Stroke Scale ("positive" if any are present)
I. Facial Droop (Ask patient to show teeth and smile.)
II. Pronator drift (Ask patient to extend arms, palms up, with eyes closed. Watch to see if one arm drifts down. If only one arm drifts, the test is positive. If both arms drift down, the results are unclear.)
III. Abnormal Speech (Ask patient to say "The sky is blue in Cincinnati.")
Glucose level <60? Refer to M406 Hyper/Hypoglycemic Protocol
Cincinnati Stroke Triage Assessment Tool (C-STAT; "positive" if ≥2)
A. Can patient move eyes normally all the way to the left and right (no=2 points)
B. Can patient hold both arms up for 10 seconds without dropping all the way to the bed (no=1 point)
C. Does patient know age and/or month and can patient follow 2 commands (no=1 point)
Cincinnati Prehospital Stroke Scale Positive? or highly suspicious of a stroke?
YES
NO
Stroke not suspected
Treat and transport as indicated per patient
Use the Cincinnati Stroke Triage Assessment Tool (C-STAT) or other evaluation tool approved by Department Medical Director to evaluate for Large Vessel Occlusion (LVO)
LVO Tool positive?
NO
YES
Last Known Well Time < 24 hours?
NO
YES
Limit scene time to <15
Call STROKE ALERT, pre-notify destination ED. Transport to the closest certified stroke center (ASRH, PSC, TSC, CSC)
Determine and document Last Known Well AND time of symptom discovery
Transport time to TSC or CSC will not disqualify for thrombolytic?
NO
YES
From Lowest to Highest Care of Capability Reference
ASRH – Acute Ready Stroke Hospital
PSC – Primary Stroke Center
TSC – Thrombectomy-capable Stroke Center
CSC – Comprehensive Stroke Center
Call STROKE ALERT, pre-notify destination ED. Transport to nearest TSC if one is located within 30 mins. If no CSC or TSC meets algorithm time parameters, transport to nearest certified stroke center.
Total transport time from scene to nearest CSC is ≤30 mins total?
YES
NO
Call STROKE ALERT, pre-notify destination ED. Transport to the closest CSC

MEDIC	1. Obtain IV access (20 gauge or larger) in the right arm proximal to the wrist, if possible ***i.*** This specific access is required for advanced neuroimaging.
ALL	**NOTES:** a. Refer to ED Capability Survey for stroke center certifications. b. Stroke Center means one of the following: Joint Commission Certified Comprehensive (CSC), Thrombectomy-Capable Stroke Center (TSC), Primary Stroke Center (PSC), Acute Stroke Ready Hospital (ASRH). c. The **Last Known Well time** is the time that the patient, or others, confirm that they were completely normal (or normal for them) prior to the onset of symptoms. This is NOT the time that the patient or bystanders first noted symptoms. If a patient woke up with symptoms present, then establish the last time the patient was noted to be at their baseline prior to going to sleep. (For example, the patient may have woken up in the middle of the night to go to the bathroom. This is the last known normal time.) If possible, bring a witness of last known normal time to the ED with the patient, and/or gather their contact information for the Stroke Team. d. **Time of Symptom Discovery** refers to the time at which the symptoms were first noticed by a reliable witness. These terms are often mistakenly used interchangeably, and so explicit capture of both ensures accuracy. Among patients with a witnessed stroke onset, these two times will be the same. e. Patients who experience transient ischemic attack (TIA) develop most of the same signs and symptoms as those who are experiencing a stroke. The signs and symptoms of TIAs can last from minutes up to one day. Thus the patient may initially present with typical signs and symptoms of a stroke, but those findings may progressively resolve. The patient needs to be transported to the hospital for further evaluation. f. Some patients who have had a stroke may be unable to communicate but can understand what is being said around them. g. Place the patient's affected or paralyzed extremity in a secure and safe position during patient movement and transport. h. In general, hypertension in stroke patients should not be treated in the prehospital setting. Treatment should only be at the direction of online medical control. i. Do not discount rapid transport just because the “window” is over; allow the ED to determine timeframes for treatment. j. Patients under 16 years of age, consider preferential transport to Cincinnati Children’s Hospital. k. A Mobile Stroke Unit (MSU) is able to diagnose and treat acute ischemic stroke and intracranial hemorrhage patients and may be an available prehospital resource for patients with suspected stroke. EMS may hand-off patient care to the MSU in the same way an ED hand-off occurs. If the MSU is en route but not yet on scene, EMS will assess the risk/benefit of immediate transport vs. a minor extension of scene time. The <15-minute scene time guidance does not apply to the MSU. l. Stroke stickers should be used to improve communications between EMS and the hospital. **REFERENCES:** American Heart Association. American Heart Association Mission Lifeline: Stroke Severity-based Stroke Triage Algorithm for EMS. 2020; https://www.heart.org/-/media/files/professional/quality-improvement/mission-lifeline/2_25_2020/ds15698-qi-ems-algorithm_update-2142020.pdf?la=en. Accessed July 7, 2020.