Stroke or Suspected Stroke

1. Follow **General Pre-hospital Care Protocol.**
2. Utilize the expanded ~~Cincinnati Pre-hospital~~ B.E.F.A.S.T Stroke Scale ~~(CPSS)~~.
   Try to elicit the following signs:
   A. **B**alance (sudden trouble walking, dizziness, loss of balance/coordination)
   B. **E**yes (trouble seeing in one or both eyes or double vision)
   C. **F**acial droop (have patient show teeth or smile)
   D. **A**rm drift (have patient close eyes and hold both arms straight out for 10 seconds~~)~~
   E. Abnormal **S**peech (have patient say "the sky is blue in Michigan")
   F. Document **T**ime last seen normal (for patient).

3. After completion of ~~If any of~~ the ~~(CPSS)~~ B.E.F.A.S.T. tests ~~are positive~~, complete these additional assessments to identify potential signs of a posterior stroke:
   A. Finger to Nose test –
      1. Demonstrate to the patient first and then have the patient repeat back to the provider.
      2. Have them attempt to touch your finger positioned approximately 1-2 feet in front of the patient at their eye level and then touch their nose, alternating arms.
   B. Headache – ask the patient if they are having a new onset posterior headache.

Any deficits found, ~~in the CPSS~~ the assessment is considered positive for stroke.

3. If the patient is demonstrating signs of hypoglycemia, measure blood glucose level.
   - If less than 60 mg/dL, administer oral glucose.

MCA Approval of Blood Glucose Testing by specific MFR Agencies **(Provide participating agency list to BETP)**
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   - Treat per **Altered Mental Status Protocol**.
4. If seizure, follow **Seizures Protocol.**
5. Document ~~time~~ last known well time ~~seen normal~~ for patient, ~~if known~~.
6. Minimize scene time, notify destination hospital as soon as possible by following the **STEMI and Stroke Alert Policy (8-41~~3~~)** if onset of signs and symptoms are potentially within 24 hours and begin transport.
7. Initiate vascular access. If possible, it is preferred to have an 18G, or high flow 22G, in the RAC. ~~(**DO NOT** delay scene time for IV.)~~

8. Monitor ECG. ~~(**DO NOT** delay scene time for ECG monitoring.)~~
9. Minimize scene time and begin transport.
   A. If possible, transport patient family or power of attorney along with patient.
10. Complete the EMTrack Stroke notification as soon as possible.

STROKE OR SUSPECTED STROKE

Initial Date: 5/31/2012
Revised Date: 2/18/2021 ***DRAFT***

Follow **General Prehospital Care Protocol**

Utilize the B.E.F.A.S.T Stroke Scale. Try to elicit the following signs:

- **B**alance (sudden trouble walking, dizziness, loss of balance/coordination)
- **E**yes (trouble seeing in one or both eyes or double vision)
- **F**acial droop (have patient show teeth or smile)
- **A**rm drift (have patient close eyes and hold both arms straight out for 10 seconds)
- Abnormal **S**peech (have patient say "the sky is blue in Michigan")
- Document **T**ime last seen normal (for patient).

POSTERIOR Stoke Assessment

- **Finger to Nose Test** – Have them attempt to touch your finger positioned approximately 1-2 feet in front of the patient at their eye level and then touch their nose, alternating arms
- **Posterior Headache** – ask the patient if they are having a new onset posterior headache

Any deficits found, the assessment is considered positive for stroke.

MCA Approval of Blood Glucose Testing by Specific MFR Agencies
Provide Agency List to BETP

[X] Yes [ ] No

Obtain blood glucose measurement

If the patient seizes, go to **Seizures Protocol**

If blood glucose is <60 mg/dL, treat per **Altered Mental Status Protocol - Adult**

- Document time last seen normal for patient, if known.
- Minimize scene time, notify destination hospital as soon as possible and begin transport.
- If possible, transport patient family or power of attorney along with patient.

Initiate Vascular Access
(Do not delay scene time)
Prefer 18G, or high flow 22G in RAC

Monitor ECG
(Do not delay scene time)