



## **STROKE TRIAGE CRITERIA**

### **PURPOSE**

To maintain a system that allows stroke patients to benefit from receiving Certified Stroke Center services; in the most expeditious manner possible.

### **AUTHORITY**

Health & Safety Code, Division 2.5, §§1797.220, 1798

### **PROCEDURE:**

- I. Suspected Stroke
  - A. Perform initial assessment
  - B. Assure the patient's airway is open, and that breathing and circulation are adequate.
  - C. Administer high flow oxygen, be prepared to assist ventilations
  - D. Position patient with head and chest elevated is less than (<) thirty (30) degrees or position of comfort
  - E. Perform a Cincinnati Pre-Hospital Stroke Scale:
    1. Assess for facial droop: have the patient show teeth or smile
    2. Assess for arm drift: have the patient close eyes and hold both arms straight out for ten (10) seconds
    3. Assess for abnormal speech: have the patient say, "You can't teach an old dog new tricks".
  - F. If the findings of the Cincinnati Pre-Hospital Stroke Scale are positive, establish onset of signs and symptoms by asking the following:
    1. To the patients – "When was the last time you remember before you became weak, paralyzed, or unable to speak clearly?"
    2. Ask the family or bystanders – "When was the last time you remember the patient being "normal" before the patient became weak, paralyzed, or unable to speak clearly?"
  - G. Perform 12-Lead electrocardiogram (EKG)
    1. Immediately transmit or notify the receiving hospital regardless of findings without delaying assessment and treatment of the patient.
  - H. If above assessments are abnormal, transport patient to a Certified Stroke receiving center.
  - I. Early notification to the Stroke receiving Center, "Stroke Alert".
  - J. Transport of patients with signs and symptoms of stroke to the appropriate hospital, a Stroke Receiving Center if onset of symptoms is under four and a half (4.5) hours, and transport time is < forty-five (45) minutes.