Stroke Assessment

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The Cincinnati Prehospital Stroke Scale

Facial Droop

(have patient show teeth or smile)

NORMAL

- Both sides of face move equally.

ABNORMAL

- One side of face does not move as well as the other side.

Arm Drift

(patient closes eyes and extends both arms straight out, with palms up for 10 seconds)

NORMAL

- Both arms move the same or both arms do not move at all.

ABNORMAL

- One arm does not move or one arm drifts down compared with the other.

Abnormal Speech

(have the patient say "you can't teach an old dog new tricks")

- Normal - Patient uses correct words with no slurring.
- Abnormal - Patient slurs words, uses the wrong words, or is unable to speak.

If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%

Version control: This document is current with respect to 2015 American Heart Association Guidelines for CPR and ECC. These guidelines are current until they are replaced on October 2020. If you are reading this page after October 2020, please contact ACLS Training Center at support@acls.net for an updated document. Version 2018.10.a

Suspected Stroke Algorithm: Goals for Management of Stroke

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Identify Signs and Symptoms of Possible Stroke
Active Emergency Response

Critical EMS assessments and actions

- O_2 Support ABCs: Give Oxygen if indicated
- Perform prehospital stroke assessment
- Check glucose
- Establish time of symptom onset (last normal)
- Triage to stroke center
- Alert hospital
- Activate stroke team

If onset >3 hours consider triage to hospital with interventional capabilities for stroke.

NINDS TIME GOALS

Within 10 min of ED Arrival

Immediate general assessment and stabilization*

- Assess ABCs, vital signs
- Provide oxygen if O_2 sat <94%
- Obtain IV access and perform laboratory assessments
- Check glucose; treat if indicated
- Obtain 12–lead ECG
- Perform neurologic screening assessment
- Order emergent CT without contrast

Within 25 min of ED Arrival

Immediate neurologic assessment by stroke team or designee

- Review patient history
- Establish time of symptom onset or last known normal
- Perform neurologic examination (NIH Stroke Scale or Canadian Neurological Scale)

Within 45 min of ED Arrival

Does CT Scan Show Hemorrhage?

No hemorrhage

Probably acute ischemic stroke; consider fibrinolytic therapy

- Check fibrinolytic exclusions
- Repeat neurologic exam: are deficits rapidly improving to normal?

Patient remains candidate for fibrinolytic therapy?

Not a candidate → **Administer aspirin**

Candidate*

Within 60 min of ED Arrival

Stroke Admission within 3 hours

Review risks/benefits with patient & family.
If acceptable:

- Give rTPA**
- No anticoagulants or antiplatelet treatment for 24 hours

- Begin post-rTPA stroke pathway
- Aggressively monitor:
  - BP per protocol
  - For neurologic deterioration
- Emergent admission to stroke unit or intensive care unit

Hemorrhage

Consult neurologist or neurosurgeon; consider transfer if not available.

- Begin stroke or hemorrhage pathway
- Admit to stroke unit or intensive care unit

** Jauch EC, Cucchiara B, Adeoye O, Meurer W, Brice J, Chan Y-F, Gentile N, Hazinski MF. " Part 11: adult stroke: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care" . Circulation. 2010;122(suppl 3):S818-S828. http://circ.ahajournals.org/content/122/18_suppl_3/S818*

*** Tissue Plasminogen Activator for Acute Ischemic Stroke. N Engl J Med. 1995:333(24)1581-1587*

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