SUSPECTED ACUTE STROKE OR INTRACRANIAL HEMORRHAGE (STROKE TRIAGE CRITERIA)

ALS STANDING ORDERS:

1. Contact Base Hospital if patient meets Stroke-Neurology Triage Criteria (see below).

2. Give no fluid or solids orally (may be risk for aspiration); dissolving Ondansetron in mouth is appropriate.

3. Monitor cardiac rhythm and document with rhythm strip.

4. Pulse oximetry, if room-air oxygen saturation less than 95%:

   ► *Provide high flow oxygen by mask or nasal cannula 6 l/min flow rate as tolerated.*

5. Blood glucose analysis, if blood glucose less than 60, administer one of:

   ► *10% Dextrose 250 mL IV*

   ► *Glucagon 1 mg IM if unable to establish IV.*

   Note: IO access may be used for dextrose administration when patient is unconscious with blood glucose less than 60, unable to establish IV and there is no response to IM glucagon.

6. For nausea or vomiting:

   ► *Ondansetron (Zofran®): ODT 8 mg (two 4 mg tablets) to dissolve orally on inside of cheek; OR,*
   4 mg IV, may repeat after approximately 3 minutes for continued nausea or vomiting.

7. If patient does not meet Stroke Triage Criteria, ALS escort to nearest ERC.

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SUSPECTED ACUTE STROKE OR INTRACRANIAL HEMORRHAGE (STROKE TRIAGE CRITERIA)

STROKE TRIAGE CRITERIA (ADULT):

1. **Ischemic Stroke Suspected:**

   - ✓ Last seen at usual neurological baseline within the past 24 hours, and
   - ✓ Responds in an appropriate manner to verbal or visual stimuli or has spontaneous eye opening, and
   - ✓ Demonstrates one or more of the following as new onset neurologic signs:
     - Arm (pronator) drift or paralysis, asymmetric to right or left arm
     - Facial paresis or droop (new onset).
     - Decreased grip strength, asymmetric to right or left hand

   Intracerebral Hemorrhage Suspected:
   Sudden, severe headache with onset in past 24 hours with any one of:

   - ✓ Vomiting (repeated), or
   - ✓ Neurological deficit (hemi-paresis or weakness, gaze to one side, or asymmetric pupils without prior eye surgery), or
   - ✓ Altered mental status, or
   - ✓ Marked blood pressure elevation (diastolic > 100 mm Hg).

2. Base contact required on all Stroke Triage designations to alert receiving facility stroke team to prepare to immediately accept patient.

3. Avoid intraosseous and external jugular lines for potential SNRC patients as these lines may allow for uncontrolled bleeding without the ability to compress the bleeding site if a patient receives thrombolytics.

4. Document the "last know well" time or onset time of stroke symptoms reported by patient, family or bystanders. Attempt to get the contact phone number of family or witness to allow receiving Stroke-Neurology Receiving Center to verify the last know well time.

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