OFFICE OF THE CHIEF OF RESCUE

June 6, 2014

INSTRUCTIONAL BULLETIN #14-16

TO: All Fire and Rescue Personnel

FROM: Ivan T. Mote, Division Chief/Rescue

RE: **JFRD Stroke Alert Policy**

The attachment is the new JFRD Stroke Alert policy. The policy has changed significantly, so please review carefully. The policy has been reviewed by the top neurologists in the area and is a best practice for the standard of care.

Any questions, contact your District or Battalion Chief.

Thank you.

ITM/mb/af

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2202

Acute Stroke

Medical Director Review Date 6-03-2014

JFRD STROKE ALERT POLICY

► **Assess patient using the Cincinnati Stroke scale**
- Abnormal Speech (" You can't teach an old dog new tricks")
- Facial Droop (Show teeth or smile)
- Arm Drift (Close eyes and hold out both arms)

► **Time of onset 6 hours or less**

► **If any of the above are positive, the patient meets stroke alert criteria**
► **After identifying stroke alert criteria, follow the hospital transport criteria below**

► **If onset of symptoms are 3 hours or less**

- Patient should be transported to any **Primary or Comprehensive** stroke center

- **Primary Stroke Centers**
  - Baptist Medical Center-South
  - Baptist Medical Center-Beaches
  - St. Vincents Medical Center-Riverside
  - St. Vincents Medical Center-Southside
  - Memorial Hospital
  - Orange Park Medical Center

- **Comprehensive Stroke Centers**
  - UF Health Hospital
  - Mayo Clinic
  - Baptist Medical Center-Downtown

► **If onset of symptoms are greater than 3 hours up to 6 hours or the patient wakes up with stroke symptoms and unknown onset time**

- Patient should be transported to a **Comprehensive** stroke center.

- **Comprehensive Stroke Centers**
  - UF Health Hospital
  - Mayo Clinic
  - Baptist Medical Center-Downtown

► **After determining the patient meets stroke alert criteria and the appropriate facility is identified**
- Notify FRCC of "Stroke Alert," destination and ETA

Acute Stroke

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TREATMENT

- Place patient on the stretcher in semi-fowlers position
- Limit scene time to a maximum of **10 minutes**
- Monitor and record vital signs every 5 minutes if the patient is unstable or every 15 minutes if the patient is stable
- **Airway/breathing management:**
  - Monitor SpO2
  - If SpO2 less than 95%, administer O2 @ 2 to 4 lpm via nasal cannula to maintain SpO2 of 95% or greater

- **Obtain IV access:**
  - Establish 18 gauge IV in the antecubital fossa if possible
    - The unaffected side is preferred but the affected side may be used

- **Initiate cardiac monitoring:**
  - Record and evaluate 12 lead ECG strip (do not delay transport)

- **Determine blood glucose level:**
  - Treat if indicated (Should be performed **BEFORE** issuing Stroke Alert)

- **Hypoglycemia** (less than **50** mg/dl) –
  - With vascular access
    - **$D_{50}W$ 12.5 grams** IV. Repeat BGL by finger stick in 5 minutes.
    - If no improvement and BGL is below **60**, repeat $D_{50}W$ 12.5 grams
    - **Contraindications-**
      - Intracranial or spinal hemorrhage
    - **Precautions-**
      - (*Dextrose causes tissue necrosis and adequate vascular access must be ensured prior to administration)*
  - Without vascular access:
    - **Glucagon 1 mg** IM (repeat BGL after 15 minutes)
    - Onset in 1 minute with a peak onset time of 30 minutes
    - **Contraindications-**
      - None in the emergency setting