

# Adult Suspected Stroke

**1**  
**Identify signs and symptoms of possible stroke**  
**Activate Emergency Response**

**2**  
**Critical EMS assessments and actions**

- Support ABCs; give **oxygen** if needed
- Perform prehospital stroke assessment
- Establish time of symptom onset (last normal)
- Triage to stroke center
- Alert hospital
- Check glucose if possible

**3**  
**Immediate general assessment and stabilization**

- Assess ABCs, vital signs
- Provide **oxygen** if hypoxic
- Obtain IV access and perform laboratory assessments
- Check glucose; treat if indicated
- Perform neurologic screening assessment
- Activate stroke team
- Order emergent CT scan or MRI of brain
- Obtain 12-lead ECG

**4**  
**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)

**5**  
**Does CT scan show hemorrhage?**

**No Hemorrhage**

**Hemorrhage**

**6**  
**Probable acute ischemic stroke; consider fibrinolytic therapy**

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

**7**  
**Consult neurologist or neurosurgeon; consider transfer if not available**

**8**  
**Patient remains candidate for fibrinolytic therapy?**

**Not a Candidate**

**9**  
**Administer aspirin**

**10**  
**Review risks/benefits with patient and family. If acceptable:**

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

**11**  
**Begin stroke or hemorrhage pathway**  
**Admit to stroke unit or intensive care unit**

**12**  
**Begin post-rtPA stroke pathway**

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

**NINDS TIME GOALS**

**ED Arrival**



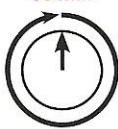
**ED Arrival**



**ED Arrival**



**ED Arrival**



**Stroke Admission**

