



Identify signs and symptoms of possible stroke
Activate Emergency Response

Critical EMS assessments and actions

- Support ABCs; give oxygen if needed
- Perform prehospital stroke assessment (Table 1)
- Establish time of symptom onset (last normal)
- Triage to stroke center
- Alert hospital
- Check glucose if possible

Immediate general assessment and stabilization

- Assess ABCs, vital signs
- Provide oxygen if hypoxicemic
- 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

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)

Does CT scan show hemorrhage?

No Hemorrhage

Hemorrhage

Probable acute ischemic stroke; consider fibrinolytic therapy

- Check for fibrinolytic exclusions (Tables 4 and 5)
- Repeat neurologic exam; are deficits rapidly improving to normal?

Consult neurologist or neurosurgeon;
consider transfer if not available

Patient remains candidate for
fibrinolytic therapy?

Not a Candidate

Administer aspirin

Candidate

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

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

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

• Begin post-rtPA stroke pathway

- Aggressively monitor:
 - BP per protocol (Tables 2 and 3)
 - For neurologic deterioration
- Emergent admission to stroke unit or intensive care unit

Rapid Acls

**Mary Beth Flynn Makic, Lauren T.
Morata**



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Table of Contents Rapid Acls

1. Understanding the eBook Rapid Acls
 - The Rise of Digital Reading Rapid Acls
 - Advantages of eBooks Over Traditional Books
2. Identifying Rapid Acls
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Rapid Acls
 - User-Friendly Interface
4. Exploring eBook Recommendations from Rapid Acls
 - Personalized Recommendations
 - Rapid Acls User Reviews and Ratings
 - Rapid Acls and Bestseller Lists
5. Accessing Rapid Acls Free and Paid eBooks
 - Rapid Acls Public Domain eBooks
 - Rapid Acls eBook Subscription Services
 - Rapid Acls Budget-Friendly Options

6. Navigating Rapid Acls eBook Formats
 - ePub, PDF, MOBI, and More
 - Rapid Acls Compatibility with Devices
 - Rapid Acls Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Rapid Acls
 - Highlighting and Note-Taking Rapid Acls
 - Interactive Elements Rapid Acls
8. Staying Engaged with Rapid Acls
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Rapid Acls
9. Balancing eBooks and Physical Books Rapid Acls
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Rapid Acls
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Rapid Acls
 - Setting Reading Goals Rapid Acls
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Rapid Acls
 - Fact-Checking eBook Content of Rapid Acls
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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