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Dear Dr. Nguyen,

thank you for your help with our manuscript. We now resubmit “Setting up a stroke team algorithm and conducting simulation-based training in the emergency department – a practical guide” taking into account the reviewers suggestions.

**Editorial comments:**

We addressed your points 1-4 on language and formatting and performed another proofreading.

Concerning point 5, we think it would be best to film steps 1-4 of the protocol (our ED algorithm) with a patient-actor whom we will recruit and suggest to film short episodes of steps 6.1., 6.2. und 7.3., 7.8 und 7.11 of the simulation training. In step 7, the manikin (simulation puppet) should be filmed.

We added the information requested in point 6. Concerning step 4.9 of the protocol: yes, the coagulation parameters are from the bloodwork. We think that this will be clear to the viewers who are interested in the topic of this video.

Advice on difficult points and suggestions for trouble shooting requested in point 7 were already present in the 4th (on the setup of the algorithm) and the 5th (on the conduct of the simulation training) paragraph and shortly elaborated on again.

**Reviewer #1:**

Medical history prior to arrival: *The identity of the patient is not transmitted before he/she arrives at the hospital and there is no direct contact to the paramedics. On the other hand, transport times are short in our densely populated region with several stroke units. As soon as the patient arrives, we see whether he/she has been treated at our hospital before and if so, information on the medical history and the last laboratory findings are printed out by the ED nurse who does the administrative admission.*  *We added this to the manuscript (step 2.3).*

Possibility to assign tasks differently to different professions or earlier/later in the whole workflow. *This is an important point to make the algorithm more generalizable, which we mentioned in the discussion. As we had stated before, each hospital should adapt the algorithm to the local circumstances and regulations.*

Allergies against contrast agents: *This is a valid point, we added this to the algorithm (step 3.2).*

Inclusion and information of relatives: *Yes, this is necessary and helpful. Added to the protocol.*

Maximal rt-PA dose: *rt-PA is approved for stroke thrombolysis with a maximal dose of 90 mg and the dose is 0.9 mg/kg. As reviewer #1 points out, patients weighing 100 kg receive 90 mg and the dose is not increase further in patients weighing > 100 kg. Corrected, thank you.*

*Should we report on the effect on DNT?* Actually, we would like to keep this piece of data for two reasons. First, we think that it shows what extent of improvement hospitals can actually expect to reach with a fixed Stroke Team algorithm. Second, most JoVE manuals also provide on piece of data to illustrate what type of results can be achieved by the method.

Reviewer #2

The authors should show alternatives to reduce the DNT with fewer staff: *Thank you for making this point that helps us to sharpen the basic principle of our concept in the discussion. We agree that the algorithm has to be tailored to each hospitals circumstances. In fact, we think that the setting-up of the algorithm in interdisciplinary team of neurologists, neuroradiologists, anaesthesiologist and stroke nurses already is an important part of the improvement process. There are certainly ways to perform all tasks with less personnel but we think that this unnecessarily delays treatment times. Often, some of the physicians involved in the algorithm are not yet board certified and need to call for supervision leading to unnecessary delays if the senior neurologist is not involved directly. We think that hospitals specializing in stroke should find a way to assemble a strong Stroke Team at short notice, as it is already common and institutionalized in trauma care.*

We thank the reviewers for their time and input and hope that our manuscript is now suitable for publication.

Sincerely,

Waltraud Pfeilschifter