POST-ACUTE STROKE CARE – NURSES EDITION

Admission to Stroke Unit / ICU/ IMC/ HDU

at least 24 hours, recommended: 72 hours

CONTINOUS CARDIAC MONITORING
(ECG, spO2, BP) (BP at least every 2 hours)

Cardiac arrhythmia
→ call physician

spO2 target: >94%
(use O2 if necessary)

SNOBS (Standardized Nursing Observations for Stroke)

Every 2 hours (for 24 hours)
Every 6 hours (for the next 48)

Level of consciousness
Speech& communication
Eye movements
Arm and Leg

FeSS-PROTOCOL (Fever, Sugar, Swallowing)

Every 6 hours

Monitor fluid balance

Normothermia: < 37.5 ° C
Normoglycemia: < 130mg/dl
Dysphagia screening!

ACUTE BLOOD PRESSURE MANAGEMENT

>220/120mmHg:
Careful reduction
(15%/24 hours)

<220/120mmHg:
No routine lowering in first 24 hours
target BP: 160/90mmHg

While/after Thrombolysis/ Thrombectomy:
<180/105 mmHg

ICH: <140/10 mmHg

AVOID ABRUPT BP LOWERING!

In stabilized stroke/ subacute: <140/90 mmHg

Start DVT prophylaxis

Initiate EARLY REHABILITATON

Education

Start early mobilization

Involve caregivers from beginning!

ACUTE STROKE CARE – NURSES EDITION

EARLY DETECTION AND STROKE CALL!

Time to CT: < 30 Min; Time to Treatment: < 60 Min

1. STROKE SCREENING: FAST

Facial droop, Arm drift, Speech problem

→ ACTIVATE STROKE TEAM / STROKE ALARM!!!

HISTORY AND INFORMATION

- Onset of symptoms
- Patients age and weight, functional status
- Medication and history
- **Check Vitals: Blood pressure, Heart rate, Oxygen saturation**
- Blood sugar
- Temperature

DO AS FAST AS POSSIBLE:

- Insert 2 IV accesses / cannula
- Draw blood (but don‘t wait for results:
  - CBC, pTT, electrolytes, renal and liver function, lipids, hba1c
  - → TRANSFER TO CT

KEEP IN MIND:

- Keep O2 saturation > 94%
- Head of bed at 30°
- Do swallowing screen before any intake
- Avoid nasogastric tubes if possible for 24 hours before / after thrombolysis
- Insert urinary catheter only IF indicated

ACUTE STROKE CARE

Acute onset of neurological deficit (FAST)

Patient's history
Symptoms, Onset?
Medication? History? Rankin?

Monitoring
Vital Signs

Neurological Assessment
NIHSS score, Vitals

Blood Diagnostics
2 PVC, Lab, Blood glucose

CT & CT-Angio
Bleeding? Hyperdense artery sign? LVO? ASPECTS?

MRI: Only if unclear time window and exceptions

0 - 4.5 hours

Plain CT

→ **Exclude bleeding**

Thrombolysis*

*if no contraindications

BP IN ACUTE STROKE:

IVT/ EVT: <180/105
>220/120: ↓ 15%/24h
< 220/120: **No routine**
BP lowering in first 24 hrs
ICH: <140/80
Long-term goal: <130/80

4.5 – 9 hours

OR Awakening from sleep, last seen normal >4.5 hours

CT/ MRI (Exclude bleeding) AND CT/ MRI- Perfusion

Infarct core volume < 70 ml AND
Ratio of critically hypoperfused volume/infarct core volume > 1.2 AND
Mismatch volume > 10 ml

Consider Thrombolysis*

*if no contraindications

ICH

BP <140 mmHg

Avoid blood pressure drops!

Consult neuro-surgeon

ADMISSION TO STROKE UNIT (IMC/ HDU/ ICU)

Criteria for thrombectomy:

0 - 6 hours	6 - 24 hours
Action: Plain CT and CTA →Exclude bleeding, Diagnose LVO ASPECTS ≥ 6 NIHSS ≥6	Plain CT and CTA & CT Perfusion →Exclude bleeding and diagnose LVO → Check Ischemic core and mismatch (DAWN& DEFUSE-3)

POST-ACUTE STROKE CARE – PHYSICIANS EDITION

Admission to Stroke Unit / ICU/ IMC/ HDU

at least 24 hours, recommended: 72 hours

NIHSS Score (after 2, 24, 48 hours and in case of clinical deterioration

Clinically stable:
CT after 24 hours (after recan)

Neurological deterioration:
Immediate brain imaging

Vascular imaging: Carotid Doppler, (CT-A/ MR-A/ DSA)

Cardiac diagnostics

ECG >24 hours (Holter)

Echocardiography
TEE if suspected endocarditis
Or Embolic stroke AND age<60Y

Lab Diagnostics

Order investigations based on likely etiology of stroke:

- CBC
- Electrolytes
- Creatinine, Urea
- AST, ALT
- TSH
- TNT
- CRP
- PTT, INR, TT
- HbA1C
- Lipid profile

If cause of stroke is still unknown, investigate other causes of stroke (depending on age, comorbidities and clinical presentation, consider:
-(Infectious) vasculitis
-Genetic stroke syndrome
- Coagulation disorder

DVT prophylaxis

ANTITHROMBOTIC THERAPY

No thrombolysis/ EVT

Minor stroke **within 24 hours** or High-Risk -TIA?

No → SAPT (Aspirin)

Yes → DAPT (Aspirin & Clopidogrel)

After 21 days:
SAPT (Aspirin)

Thrombolysis/EVT

After excluding hemorrhage on CT (after 24 hours)

SAPT (Aspirin)

Change to anticoagulation if indicated