ACS: Acute Stroke Care for Nurses

Stroke patients are a specialized patient population with specific assessment, education and documentation requirements. Stroke care in a Comprehensive Stroke center and in a specialized unit leads to better patient outcomes. This ACS tool is a guide to assist with the care for MVHS stroke patient during a Code Stroke.

A (Acute monitoring)

Neuro checks
- ✓ NIHSS within 15 minutes of arrival
- ✓ NIHSS Q 15 minutes until treatment decision is made
- ✓ Follow protocol based on treatment option

Vital Signs
- ✓ Full set of vital signs within 15 minutes of arrival
- ✓ VS Q 15 minutes until treatment decision is made
- ✓ Follow protocol based on treatment option
- ✓ Complete VS per policy on admitted unit

Thrombolytic Therapy-*Print & fill out Thrombolytic post vitals-neuro check monitor form & return to Nurse Manager*
- ✓ May utilize tip sheet
- ✓ Monitor & document NIHSS **&** VS per protocol
- ✓ Monitor for angioedema & document appropriately
- ✓ Monitor changes in neuro status, BP or c/o headache or other adverse reactions

Mechanical Thrombectomy- *Print & fill out Post NEV puncture site pulse checklist form & return to Nurse Manager*
- ✓ May utilize tip sheet
- ✓ Pulses checked & document pre **&** post procedure
- ✓ Monitor & document NIHSS **&** VS per protocol
- ✓ Monitor & document site checks per protocol

S (Stroke complications)

Evolving stroke
- ✓ Patient continues to deteriorate regardless of treatment
- ✓ Follow up with any advanced directives of patient wishes

Aspiration prevention/aspiration pneumonia prevention
- ✓ Nursing dysphasia screening for all stroke patients
- ✓ Keep patient NPO if failed dysphasia screening until assessed by SLP
- ✓ Verify SLP assessment documentation is completed **prior** to any PO intake & verify times
- ✓ Review any medication administration routes with MD if patient is NPO (be sure PO meds are changed to alternate route in orders-ie: PO Tylenol ordered & documented PO but was actually given via NG-tube)

Immobility prevention
- ✓ Initiate DVT prophylaxis (medications, devices, positioning)
- ✓ Apply & document DVT prophylaxis within 24 hours of admission (SCD's, etc.)
- ✓ If patient refuses DVT interventions, be sure to document refusal
- ✓ Monitor Braden scores & skin protection
- ✓ Reposition patient per protocol
- ✓ Encourage OOB & mobility

Urinary Tract Infection
- ✓ Minimize foley catheter use
- ✓ Assess for urinary retention
- ✓ Monitor urinary output (bladder scan prn)

C (Care & Communication)

Handoff communication with Nursing
- ✓ SBAR
- ✓ Type & location of stroke
- ✓ Treatments provided & where is patient monitoring if Thrombolytic therapy or Mechanical Thrombectomy completed
- ✓ NIHSS at bedside upon transfer to unit with both RN's
- ✓ Other pertinent findings, orders or concerns

With Providers
- ✓ Change in neurological status or increase by 4 points on NIHSS. If increased but less than 4, reassess in one hour. If increased again (trending up), notify provider immediately
- ✓ Blood Pressure changes or outside parameters
- ✓ Possible stroke complications
- ✓ Changes in intake and/or swallowing function
- ✓ Monitor ischemic stroke patients for antithrombotic, statin & VTE prophylaxis (or documentation if not ordered)

With Patients and/or Caregivers
- ✓ Regular communication including patient status, changes and plan of care
- ✓ Patient specific stroke education
  - Patient specific risk factors
  - Patient specific treatments provided along with any adverse reactions to be aware of
  - New medication teaching
  - Signs & symptoms of stroke
  - Importance of notifying EMS with any stroke symptoms
  - Follow up care requirements & importance of care follow-through