Nursing Guidelines of Care for the Hemorrhagic Stroke Patient

Inclusion criteria: All patients with Subarachnoid and Intracerebral Hemorrhages

Stroke Team
- Confirm Notification of the Rapid Response/Stroke Team
- NIHSS on admission and follow-up 24hrs post presentation by RRT
- Repeat NIHSS prior to if length of stay is less than 24 hrs

Supportive Care and Treatment of Acute Hemorrhagic Stroke

Assessment
- Neuro Checks and Vital signs as ordered and per patient status.
- Notify physician:
  - For any signs and symptoms of neurological deterioration, including:
    - Change in level of consciousness- lethargy, sedation, increased confusion, agitation
    - Neurological deficits, new or increased
    - Nausea and vomiting, new onset
    - Headache, new onset or worsening
  - Vital Signs:
    - SBP > 160 or < 140
    - Heart rate > 100 or < 50
    - Temperature ≥ 100.5°F
    - O2 sats < 90% on room air or RR > 24

- Goal for blood glucose is <180mg/dL

VTE Prevention: High risk for DVT formation; anticoagulation may be contraindicated due to high risk of bleeding
- Complete Daily VTE Assessment
- SCDs unless contraindicated

Activity/Safety
- Nursing Swallow Screen prior to first po intake, including medications.
  - If Failed: Keep NPO, notify MD and SLP for swallowing evaluation. If Passed: Implement diet order.
- Activity as ordered by the physician
- Turn and position at least every 2 hours while in bed if unable to move self
- Complete Daily Fall Risk Assessment

Nursing Screens (nursing-initiated consults that do not require a physician order)
- Case management/Discharge Planner
- Physical Therapy
- Occupational Therapy
- Speech/SLP if Nurse Swallow Screen failed, Speech Impaired or has Cognitive Deficits
- Dietician if new diagnosis of DM, Hgb A1C > 9, or BMI > 30

Patient/Caregiver Stroke Education
- Provide and Review Stroke Education Packet
- Document teaching under ‘patient education’ tab
- Stroke Education Packet should include all of the below:
  - Personalized Risk Factor Modification (Smoking Cessation, DM, HTN, Cholesterol, Sleep Apnea, Obesity)
  - Warning Signs and Symptoms of stroke (FAST)
  - How to call EMS
  - Medication Instructions/Compliance
  - Follow-up Appointment with Physician

Origin: 10/13
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Nursing Information Only

- NIHSS (National Institute of Health Stroke Scale) is a noninvasive and valid assessment tool used to evaluate neurological status; reliable predictor of infarct size, location, and stroke severity/disability
  - 0 = No Stroke/No Deficits
  - 1-4 = Minor Stroke/Mild Deficits
  - 5-15 = Moderate Stroke/Moderate Deficits
  - 15-20 = Moderate/Severe Stroke/Major Deficits
  - 21-42 = Severe/Devastating Stroke/Major Deficits
- Blood pressure should be monitored and controlled to balance the risk of stroke, hypertension-related rebleeding and perfusion to the brain.
- Patients with hemorrhagic strokes may be a greater risk for rebleeding, hydrocephalus, cerebral vasospasms, and seizures.
- Avoiding hypovolemia and hyponatremia is recommended to prevent volume contraction, vasospasms, and increased brain tissue damage.
- Hyperthermia in stroke patients may damage penumbra and increase brain damage.
- Sources for elevated temperature should be identified & treated. Administer antipyretic (ex. Tylenol) as ordered to prevent hyperthermia.
- It is recommended that O2 @ 2-4L/NC should be administered to maintain O2 sats > 94% but a physician order for O2 therapy is required. O2 is NOT recommended for non-hypoxic patients with acute ischemic stroke.
- Persistent hyperglycemia (>200 mg/dL) in the first 24 hours of acute stroke has been shown to result in worse patient outcomes than those with normoglycemia. Goal for blood glucose < 180 mg/dL.
- If glycemic order set is implemented, monitor closely to prevent hypoglycemia (<60mg/dL).
- HOB elevation is recommended for patients at risk for ICP & aspiration pneumonia.
- Majority of stroke patients will have some sort of swallowing difficulty and may be prone to aspiration pneumonia.
- Cognitive deficits may include being impulsive, unaware of safety risks, poor or short term memory problems etc.
- Monitor for fall risk. Stroke patients may be prone to being impulsive or unaware of deficits, increasing likelihood for falls
- Follow up CT/MRI of head is recommended at 24 hrs after tPA before starting anticoagulants or antiplatelet therapy.

Additional Stroke Resources

Stroke Resource Center on Nurses Portal
AHA/ASA Guideline: Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage
http://stroke.ahajournals.org/content/40/3/994.full
American Association of Neuroscience Nurses (AANN) Clinical Practice Guidelines @ www.aann.org
Care of the Patient with Aneurismal Subarachnoid Hemorrhage
American Heart/American Stroke Association @ www.heart.org
Free NIHSS Certification @ www.ems4stroke.com

Implemented By ___________________________, RN    Date/Time ____________________________

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Reference