Delivering safe stroke care at hospitals without acute stroke units during the COVID-19 pandemic

Appendix 8: Nursing observations required post-thrombolysis

Arrival on the ward

- All stroke patients should be 'nil by mouth' for the first 24 hours or until the next acute stroke consultant review.
- NG tube and urinary catheter placement should be avoided wherever possible for the first 24 hours following thrombolysis. Every effort should be made to toilet the patient prior to consideration of a urinary catheter.
- All thrombolysed patients require an intensive schedule of monitoring, as outlined below, and should be attached to continuous monitoring.

On arrival on the ward

- BP
- Heart rate
- Respiration rate
- Oxygen saturation
- Temperature
- Neurological observations (Glasgow Coma Scale score, pupils, limb movement)
- Check all puncture sites for bleeding
- Check tongue for swelling

First 2 hours after thrombolysis

- Every 15 minutes:
    - BP
    - Heart rate
    - Respiration rate
    - Oxygen saturation
    - Check all puncture sites for bleeding
    - Check tongue for swelling
- Each hour:
    - Temperature
    - Neurological observations (Glasgow Coma Scale score, pupils, limb movement)

Next 6 hours

- Every 30 minutes:
    - BP
    - Heart rate
    - Respiration rate
    - Oxygen saturation
    - Check all puncture sites for bleeding
- Each hour:
    - Temperature
    - Neurological observations (Glasgow Coma Scale score, pupils, limb movement)

Next 16 hours

- Each hour:
  - BP
  - Heart rate
  - Respiration rate
  - Oxygen saturation
  - Check all puncture sites for bleeding
  - Temperature
  - Neurological observations (Glasgow Coma Scale score, pupils, limb movement)

Thereafter (i.e. between 24 and 72 hours after admission)

- Follow the FeSS protocol (https://www.sciencedirect.com/science/article/pii/S0140673611614852) for the next 48 hours, then routine observations thereafter, unless additional observations indicated.

Special notes

- All BP, pulse and oxygen saturation measurements should be taken from the unaffected arm, unless contraindicated.
- Manual BP measurement must occur to confirm BP >185/110 mmHg or if the patient is hypotensive.

Actions

- Within the first 24 hours on the acute stroke unit, report immediately to doctor if:
  - SBP >185 mmHg
  - DBP >110 mmHg
  - Heart rate >100 beats per minute
  - Heart rhythm changes
  - Rate or nature of respiration changes
  - Neurological state deteriorates
  - Bleeding occurs
  - Temperature rise of 1°C from baseline.