

REGISTERED NURSE

GENERAL STROKE TREATMENT PACK



GENERAL STROKE TREATMENT CHECKLIST

SNOBS

GENERAL STROKE TREATMENT CHECKLIST

PATIENT NAME:

The term “general treatment” refers to treatment strategies aimed at stabilising the critically ill patient in order to control systemic problems that may impair stroke recovery; the management of such problems is a central part of stroke treatment. General treatment includes respiratory and cardiac care, fluid and metabolic management, blood pressure control, the prevention and treatment of conditions such as seizures, venous thromboembolism, dysphagia, aspiration pneumonia, other infections, or pressure ulceration, and occasionally management of elevated intracranial pressure.¹

It is common practice to actively manage neurological status and vital physiological functions such as blood pressure, pulse, oxygen saturation, blood glucose and temperature. Neurological status can be monitored using validated neurological scales such as the NIHSS or SNOBS Scale. There is little direct evidence from randomised clinical trials to indicate how intensively monitoring should be carried out, but in stroke unit trials it was common practice to have a minimum of 4-hourly observations for the first 72 hours after stroke.¹

During and after rt-PA TREATMENT please carry out the following orders as appropriate

Completed	Comments	Completed	Comments
Keep NPO till swallowing screen has been done. If dysphagia present keep NPO & repeat screen in 24h ¹	☐	Antibiotic prophylaxis is not recommended in immunocompetent patients ¹	☐
It is recommended that stroke patients receive antithrombotic therapy ¹	☐	Monitoring serum glucose levels is indicated ¹	☐
Oral anticoagulation is recommended after ischaemic stroke associated with Atrial Fibrillation ¹	☐	Treatment of serum glucose levels >180 mg/dl (>10 mmol/l) with insulin titration is indicated. Severe hypoglycaemia (<50 mg/dl [<2.8mmol/l]) should be treated with intravenous dextrose or infusion of 10–20% glucose ¹	☐
It is recommended that patients not requiring anticoagulation should receive antiplatelet therapy ¹	☐	Routine blood pressure lowering is not recommended following acute stroke	☐
Intermittent monitoring of neurological status, pulse, blood pressure, temperature and oxygen saturation is indicated for 72 hours in patients with significant persisting neurological deficits ¹	☐	Cautious blood pressure lowering is recommended in patients with extremely high blood pressures (>220/120 mmHg) on repeated measurements, or with severe cardiac failure, aortic dissection, or hypertensive encephalopathy ¹	☐
For stroke and TIA patients seen after the acute phase, 24-hour Holter ECG monitoring should be performed when arrhythmias are suspected and no other causes of stroke are found ¹	☐	Abrupt blood pressure lowering should be avoided ¹	☐
Regular monitoring of fluid balance and electrolytes is indicated in patients with severe stroke or swallowing problems ¹	☐	Low blood pressure secondary to hypovolaemia or associated with neurological deterioration in acute stroke should be treated with volume expanders ¹	☐
Normal saline (0.9%) is indicated for fluid replacement during the first 24 hours after stroke ¹	☐	NIHSS score 24 hours post admission ¹	☐
		Modified Rankin Score 24 h post admission ¹	☐

Nurse, name

Staff number

Signature

Date

Time

Reference: 1. European Stroke Organization guidelines 2008. Cerebrovasc Dis 2008;25(5):457-507

These checklists are provided as an example. Please adapt to your local regulations and prescribing information before use.

SNOBS

Standardised Nursing Observations for Stroke

Deterioration is defined as a ≥ 2 point worsening in either conscious level, arm, leg or eye movement scores, and/or a ≥ 3 point worsening in speech score, between consecutive neurological assessments.

- Scores should represent what is seen at each time point, not what the assessor thinks they can see.
- First impressions should be recorded by ticking one box in each category.
- Any reduction in score, in any category, should be confirmed by repeat observation by another nurse.

			MINUTES				HOURS											
			Base-line	15	30	45	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	
Conscious level	Fully conscious, alert	6																
	Sleepy, can be awakened to full consciousness	4																
	Reacts to voice/stimulus, cannot be fully awakened	2																
	Coma: no response to stimulus	0																
Speech & communication	Normal, no communication difficulty	10																
	Mild communication difficulty	6																
	Moderate difficulty, no proper sentences	3																
	Severe difficulty, 1 or 2 words or fewer	0																
Eye movements	Normal conjugate movement, eyes move left and right equally	4																
	Difficulty looking to affected side (lateral paresis)	2																
	Eyes deviated at rest (away from affected side)	0																
Arm	Raises arm, normal strength	6																
	Raises arm with reduced strength, elbow straight	5																
	Raises arm against gravity with bent elbow	4																
	Can move arm but not against gravity	2																
	Paralysed, no movement	0																
Leg	Raises leg, normal strength	6																
	Raises straight leg with reduced strength	5																
	Raises leg against gravity but with bent knee	4																
	Can move leg but not against gravity	2																
	Paralysed, no movement	0																

