Craigavon Area Hospital

Guidelines for

**Nursing Management Pre /Post Thrombolysis in Stroke**

1. A senior nurse in the stroke unit will be required to monitor the patients condition post Thrombolysis on a continual basis for the first hour
2. Keep patient nil orally and commence IV fluids as required
3. Maintain head position at 30 degree elevation if a deterioration in consciousness level occurs
4. Commence patient on Stroke Care Pathway
5. Keep patient and relatives updated

**Equipment required:**

Cardiac monitor required
Drip stand to hold the Perfusor pump
Thrombolysis admission pack contains (nursing protocols, CNS observation chart, FBC chart, syringe driver prescription chart and labels)

**Nursing Management during rt-PA infusion**

1. Reassure patient
2. Maintain Bed rest
3. Connect patient to the cardiac monitor including ECG (provides a more accurate reading of oxygen sats level)
4. Set up the Perfusor pump and inset the syringe containing lysis and calculate the infusion rate. Dosage calculation chart is enclosed in the Thrombolysis admission pack
5. Store second syringe in the fridge (if appropriate)
6. Record observations before the infusion on CNS chart. (CNS and vital signs) and continue with:
7. **15 minute intervals during the infusion**
8. Observe the patency of the Perfusor pump and check the adcyte and record on syringe driver chart
9. Seek immediate medical attention if there is a change in clinical observations (see section relating to clinical observations)

**General Management**

1. Do not remove adcyte
2. Do not give Aspirin / Anticoagulant for 24 hours
3. Avoid NG tube insertion for 24 hours
4. Do not catheterise for 24 hours post Thrombolysis (unless clinically indicated)
5. Keep Nil Orally for 24 hours (possibility of neurosurgery)
6. Give prescribed IV fluids
7. Bed rest for 24 hours

**Stop Alteplase infusion if:**

1. Anaphylaxis
2. Marked hypotension
3. Neurological deterioration, decreased consciousness level (2 points GCS eye or motor score) NIHHS > 4 points
4. Increased BP single reading > 230/120mgHg
5. Increased BP > 185/110 mgHg if sustained (2 readings 5 minutes apart) or if associated with neurological deterioration
6. Major systemic bleeding – GI or intra-abdominal haemorrhage

*Seek immediate medical attention*
Signs of Intracranial Haemorrhage

1. Fall in GCS
2. Any neurological deterioration (any limb weakness, speech disturbance)
3. New onset headache
4. Nausea /Vomiting
5. Rise in blood pressure

*If any of the above occurs seek immediate medical assistance*

Signs of Anaphylaxis

1. Marked Hypotension
2. Acute onset of shortness of breath
3. Facial swelling
4. New onset of wheeze

If any of the above occurs STOP THE INFUSION seek immediate medical attention, get anaphylaxis pack from crash trolley
Changes in Clinical Observations that require Medical Attention

- **GCS**  
  Drops one point or more

- **Blood Pressure**  
  Single reading >230/120mgHg  
  Two repeat readings five minutes apart

- **Pulse**  
  > 100 BPM < 50 BPM

- **Temperature**  
  > 37.5 degrees centigrade

- **Oxygen Saturation Levels**  
  < 95 % (give prescribed O2 therapy)

- **Respirations**  
  > 20 BPM < 9BPM
Nursing Management for first 24 hours

1. Maintain Bed rest for 24 hours
2. Ensure patient is assessed for a medium to high risk pressure mattress
3. Record GCS levels, blood pressure, pulse, respirations and oxygen saturation levels:
4. 15 minute intervals for 2 hours following the infusion.
5. 30 minute intervals for 6 hours
6. Hourly for 16 hours
7. 2-4 hourly depending on condition

Observe for abnormalities and seek immediate medical attention

Nursing Management 24 – 48hrs
1. After 24 hours record clinical observations, Temperature, pulse, Blood Pressure, Respirations and oxygen saturation levels on a MEWS chart 2-4 hourly depending on patients condition
2. Liase with medical staff regarding a repeat CT scan of Brain 24 hours post Thrombolysis or earlier if clinically indicated
3. Keep patient Nil Orally for 24 hours. Speech and Language therapist to assess after 24 hours
4. Bedrest to be maintained for 24 hours
Nursing Management after 48 hours

1. Check clinical observations BD via mews chart until otherwise directed by medical staff

2. Liase with Multidisciplinary team to assess patient for suitability for rehabilitation

Signature Date

Signature Date

Review in 12 months Date