**Post tPA monitoring**

**Monitoring and documentation for first 24 hours after tPA administration**

 Blood pressure and neuro checks (modified NIH):

* Q 15 min for 2 hours
* Q 30 min for 6 hours
* Q 1 hr for 16 hours

**Nursing Considerations**

* Maintain BP < 180/105 first 24 hours
* Monitor carefully for suspected intracranial hemorrhage
	+ Acute neuro deterioration
	+ New headache
	+ Acute HTN
	+ Nausea/vomiting
* Monitor for signs of bleeding
	+ New hematomas or ecchymosis
	+ Hematuria or GI bleeding
	+ Bleeding from puncture sites
* If any changes in patient condition 🡪 notify physician and call Neuro RRT immediately

***Invasive procedures such as arterial punctures or insertion of catheters or NG tubes should be avoided in the first 24 hours after tPA******if the patient can safely be managed without them.***

**Hand off to EMS**

* Transfer monitoring times from your cheat sheet to EMS transfer form for continuity of care including answering all time administration blanks on front.
* Do the next vitals and neuro checks with EMS
* Copy the filled out form and scan into the medical record – the original goes with EMS

**Maury Regional Medical Center\* Patient Label**

**Reference Sheet for Neuro Checks**

|  |  |
| --- | --- |
| **Question** | **Helpful Hints** |
| **Level of Consciousness** | Use voice to wake a sleeping patient, then touch. May require vigorous stimulation |
| **Ask Patient to Close Eyes & Make a Fist** | If the patient’s unaffected arm is amputated, then ask them to wiggle their toes |
| **Lateral (horizontal) Gaze** | Ask patient to follow your finger or face – moving eyes horizontally back and forth or if they cannot see your finger due to vision impairment, ask them to follow your face or head and move horizontally back and forthIn altered or ventilated patients, take care and perform the oculocephalic maneuver – hold the eyes open and move the head quickly to one side – the patient’s eyes should look in the opposite direction (normal). Eyes that follow the direction of the head are abnormal and score a 2. Caution should be taken in intubated patients as not to dislodge the tube and also in trauma patients with cervical spine injury. |
| **Visual Field Testing** | Patient with both eyes open, count 1 – 2 – 5 fingers in all visual fieldsIf the patient is altered or has a language barrier, test using confrontation - come at the patient in the outer quadrants of the visual field quickly, if they have vision, they should blink  |
| **Motor Function – Left/Right Arm** | Ask patient to lift arm 90 degrees if sitting or 45 degrees is supine for 10 seconds. If patient is unable to lift the affected arm, lift it for them to see if they can hold it up for 10 seconds. Test each side separately. |
| **Motor Function Left/Right Arm** | Ask patient to lift leg 30 degrees if supine for 5 seconds. If the patient cannot lift the leg, you may do so for them and ask them to hold it up for 5 seconds.  |
| **Speech (Content)** | Use the picture cards or objects that are easily answered. Ask the patient to name the objects on the card or a pen, or a phone, glasses, etc. Also – ask them to read the sentences  |
| **Sensory** | Ask patient to close their eyes. Touch the patient on one side or the other and ask which side they are being touched – test face, arms and legs.You may also touch both sides of the face, arms or legs and ask if they feel the same. |

This is the Modified version of the Full NIH Stroke Scale. The Full NIH stroke scale must be documented once per shift.

Ensure you are clicking in the “total” box to get a score on each neuro check.

Patients are worsening with increasing numbers. A Neuro RRT call should be initiated with increasing score.

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 **Patient Label**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Level of Consciousness** | Alert | 0 |  | **Motor Function - Right Leg** | No drift | 0 |
|  | Sleepy but arouses | 1 |  |  | Drifts down, does not hit bed | 1 |
|  | Can’t stay awake | 2 |  |  | Drifts down, hits bed | 2 |
|  | No purposeful movement | 3 |  |  | Can move but cannot lift | 3 |
| **Ask patient to Close eyes and make a fist** | Obeys both | 0 |  |  | No movement | 4 |
|  | Obeys one command | 1 |  | **Motor Function - Left Leg** | No drift | 0 |
|  | Obeys neither command | 2 |  |  | Drifts down, does not hit bed | 1 |
| **Lateral (horizontal) Gaze** | Normal side to side mvmt | 0 |  |  | Drifts down, hits bed | 2 |
|  | Partial side to side mvmt | 1 |  |  | Can move but cannot lift | 3 |
|  | No side to side mvmt | 2 |  |  | No movement | 4 |
| **Visual Field Testing** | Normal visual fields | 0 |  | **Speech** | Correct full sentence/naming | 0 |
|  | Blind upper OR lower field on one side | 1 |  |  | Wrong or incomplete sentences | 1 |
|  | Blind upper AND lower field on one side | 2 |  |  | Words do not make sense | 2 |
|  | Blind in both eyes/all 4 fields | 3 |  |  | Can’t speak at all | 3 |
| **Motor Function - Right Arm** | No drift | 0 |  | **Sensory** | Normal | 0 |
|  | Drifts down, does not hit bed | 1 |  |  | Decreased sensation | 1 |
|  | Drifts down, hits bed | 2 |  |  | Can’t feel, no pain withdrawal | 2 |
|  | Can move but cannot lift | 3 |  | **Total** | Add all scores and record  |  |
|  | No movement | 4 |  |  |  |  |
| **Motor Function - Left Arm** | No drift | 0 |  |  |  |  |
|  | Drifts down, does not hit bed | 1 |  |  |  |  |
|  | Drifts down, hits bed | 2 |  |  |  |  |
|  | Can move but cannot lift | 3 |  |  |  |  |
|  | No movement | 4 |  |  |  |  |

**Neuro Check Scoring Reference:**

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