

Stroke (CVA) Nursing Care Plan

A five-column acute ischemic stroke plan covering reperfusion timelines, hourly neuro checks, dysphagia protection, aphasia communication, and secondary prevention teaching.

QUICK ANSWER

For acute ischemic stroke, prioritize: ineffective cerebral tissue perfusion → risk for aspiration → impaired verbal communication → impaired mobility/falls → skin integrity → family processes. Core interventions are protecting reperfusion time targets (CT ≤ 25 min, needle ≤ 60 min), hourly neuro checks for 24 h, strict NPO until a validated dysphagia screen passes, BP to the ordered target (below 180/105 after thrombolysis), normoglycemia and normothermia, aphasia-appropriate communication, early mobilization, and BE-FAST plus anticoagulation teaching at discharge.

Assessment (subjective + objective)

Subjective (from family): last known well 06:40; sudden right-sided weakness and slurred speech while eating breakfast; history of atrial fibrillation, hypertension, and missed apixaban doses.

Objective: NIHSS 12; right facial droop; right arm drift to bed within 5 s; right leg 3/5; expressive aphasia; dysphagia screen failed (wet voice, cough with 3 oz water); BP 186/102; glucose 142; CT without hemorrhage; CTA showing left M2 occlusion; SpO₂ 94% RA.

Priority NANDA-I diagnoses

1. **Ineffective cerebral tissue perfusion** related to arterial occlusion AEB NIHSS 12, right hemiparesis, and left M2 occlusion on CTA.
2. **Risk for aspiration** AEB failed bedside dysphagia screen with wet voice and cough.
3. Impaired verbal communication (expressive aphasia) AEB inability to name objects.
4. Impaired physical mobility and risk for falls AEB right leg strength 3/5.
5. Risk for impaired skin integrity related to immobility.
6. Interrupted family processes / caregiver role strain.

NOC outcomes (SMART)

- NIHSS stable or improved with no new focal deficit on hourly neuro checks for the first 24 h.
- Zero aspiration events; patient remains NPO until a formal swallow evaluation clears a diet.
- BP maintained within the ordered post-thrombolytic range ($< 180/105$) for 24 h.
- Patient communicates needs using a board or yes/no system within 24 h.
- No pressure injury and no fall during admission; out of bed with therapy by day 2 if stable.

NIC interventions and rationale

- **Protect the time-critical window: door-to-CT ≤ 25 min, door-to-needle ≤ 60 min, and escalate for thrombectomy candidacy** — every 15 minutes saved in reperfusion improves the odds of functional independence.
- **Neuro checks (NIHSS or focused exam) hourly for 24 h, then per protocol** — deterioration signals hemorrhagic conversion, edema, or reocclusion.

- **Keep NPO — including meds and ice chips — until a validated dysphagia screen is passed** — dysphagia screening before any oral intake is the single most effective intervention against stroke-associated pneumonia.
- **Manage BP to the ordered target; avoid aggressive lowering in untreated ischemic stroke** — permissive hypertension preserves collateral perfusion in the penumbra, but post-thrombolytic patients require < 180/105.
- **HOB flat or 30° per order, head midline, avoid neck flexion and hip flexion > 90°** — supports venous drainage and cerebral perfusion pressure.
- **Maintain normoglycemia (140–180) and normothermia; treat fever promptly** — hyperglycemia and hyperthermia both expand infarct volume.
- **Communication support: yes/no questions, picture board, extra time, no sentence-finishing** — expressive aphasia preserves comprehension; talking louder or for the patient is a common avoidable harm.
- **Early mobilization with PT/OT/SLP once stable, plus 2-hourly repositioning and VTE prophylaxis.**
- **Secondary prevention teaching before discharge: BE-FAST recognition, anticoagulation adherence for AF, BP and lipid targets, smoking cessation** — nonadherence to anticoagulation caused this admission.

Evaluation

At 24 h post-thrombectomy: NIHSS 4, no new deficit on hourly checks, BP range 142–176/78–96 within target, SLP cleared dysphagia level 2 diet with no aspiration events, patient uses a picture board reliably, out of bed with PT on day 2, skin intact, no falls. Family verbalizes BE-FAST and the apixaban plan. Outcomes met.

Frequently Asked Questions

What is BE-FAST and why has it replaced FAST?

Balance, Eyes, Face, Arms, Speech, Time. Adding balance and vision catches posterior-circulation strokes that plain FAST misses — roughly 14% of strokes in some series.

Why is permissive hypertension allowed in ischemic stroke?

Why is dysphagia screening the top nursing priority after perfusion?

Stroke-associated pneumonia is a leading cause of death after stroke, and it is largely preventable. A validated bedside screen before any oral intake — including oral medication — measurably reduces it.

How do I communicate with a patient who has expressive aphasia?

Sources & Further Reading

1. **Powers, W. J., et al..** Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update. *Stroke*, 50(12), e344–e418.
2. **Eltringham, S. A., et al..** Impact of dysphagia assessment and management on risk of stroke-associated pneumonia: a systematic review. *Cerebrovascular Diseases*, 46(3–4), 99–107.

Related Resources

→ Full nursing care plan library → Hypertension care plan → Pneumonia care plan → NANDA-I diagnosis list