

Stroke: Recognise & Act

Adult nursing guide | Sudden neurological change is an emergency

Ischaemic stroke	Haemorrhagic stroke
An artery is blocked, reducing blood flow to part of the brain. Causes include local thrombosis and emboli, such as those associated with atrial fibrillation.	A blood vessel ruptures. Bleeding may occur within brain tissue (intracerebral haemorrhage) or around the brain (subarachnoid haemorrhage).

Symptoms alone cannot reliably distinguish the type. Urgent brain imaging guides treatment. A transient ischaemic attack (TIA) causes transient focal symptoms without acute infarction; symptoms resolving does not make assessment optional.

Recognise sudden changes: BE FAST

B - Balance	New imbalance, loss of coordination or difficulty walking.
E - Eyes	New visual loss or double vision.
F - Face	Facial droop or asymmetry.
A - Arm	One-sided weakness or arm drift; leg weakness may also occur.
S - Speech	Slurred speech, difficulty finding words or understanding language.
T - Time	Activate the stroke/emergency pathway immediately.

Sudden severe headache, vomiting or reduced consciousness may also occur. Posterior circulation stroke may present with marked imbalance, double vision or swallowing difficulty; FAST alone can miss it. [1,2]

First nursing actions

Activate help and assess ABCs. Record the exact **last known well** time: when the person was last at their usual neurological baseline, not simply when symptoms were discovered.

Check glucose promptly: hypoglycaemia can mimic stroke; treat according to protocol.

Assess: consciousness, focal deficits, vital signs, oxygen saturation and rhythm. Use NIHSS when trained.

Prepare urgent imaging: establish IV access, obtain ordered tests and record anticoagulants with the last dose time. Do not delay imaging for routine tasks. [2]

Keep nil by mouth, including water and oral medicines, until a validated swallowing screen is completed. Do not give aspirin before intracranial bleeding has been excluded and treatment is prescribed. [2,4]

Acute Treatment Decisions

Time matters, but imaging and eligibility determine treatment.

Brain and vascular imaging

An urgent non-contrast CT usually checks for bleeding. An early CT can appear normal in ischaemic stroke. CT angiography identifies large-vessel blockage; advanced CT/MRI may help select patients for later treatment. [2,3]

Ischaemic stroke treatment	Key nursing understanding
IV thrombolysis	Alteplase or tenecteplase may be used in eligible patients, generally within 4.5 hours of onset/last known well. Selected later or unknown-onset strokes may qualify using advanced imaging.
Mechanical thrombectomy	Catheter-based clot removal for selected large-vessel occlusions. Some patients qualify up to 24 hours; this is not a reason to delay presentation.
Antithrombotic treatment	Antiplatelet therapy is commonly used after bleeding is excluded. After IV thrombolysis, antiplatelets/anticoagulants are generally withheld for 24 hours pending follow-up imaging and specialist orders.

Not every ischaemic stroke receives thrombolysis. The team considers disabling deficits, imaging, bleeding risk, blood pressure, recent procedures and anticoagulant exposure. Do not rule out treatment solely because the patient woke with symptoms. [3]

Blood pressure: follow the stroke-specific target

Do not rapidly normalise blood pressure on your own. Targets differ for ischaemic stroke, haemorrhage and reperfusion treatment. For IV thrombolysis, BP is typically required to be **below 185/110 mmHg before treatment** and maintained **below 180/105 mmHg for 24 hours afterward**. Follow the current local protocol and prescribed monitoring. [2,3]

Haemorrhagic stroke

Priorities include controlled BP management, urgent reversal of anticoagulation when indicated, neurological monitoring and specialist/neurosurgical review. Treatment depends on the location and cause of bleeding. **Thrombolysis is not treatment for haemorrhagic stroke.** [5]

After reperfusion treatment: report sudden headache, vomiting, worsening deficits or reduced consciousness immediately. These may indicate intracranial bleeding. Monitor for bleeding elsewhere and for airway swelling/angioedema. [3]

Ongoing Nursing Care

Prevent complications and support recovery and independence.

Priority	Nursing action
Neurological monitoring	Trend consciousness, pupils, limb function and speech. Escalate new deficits, seizures, vomiting or declining consciousness immediately.
Airway / oxygenation	Assess airway protection and breathing. Give oxygen for hypoxaemia according to the prescribed target; routine oxygen is not needed when saturation is adequate.
Swallowing / nutrition	If screening fails, keep oral intake withheld and refer for specialist assessment. Follow the prescribed texture, fluids and feeding route; provide oral care. A gag reflex does not prove safe swallowing.
Mobility / skin / VTE	Reposition, protect pressure areas and support weak limbs. Do not pull on the affected arm. Begin individualised rehabilitation when stable; provide prescribed VTE prevention.
Communication / cognition	Aphasia affects language; dysarthria affects speech clarity. Allow time, use short instructions and communication aids. Do not assume aphasia means reduced intelligence.
Neglect / visual loss	Assess safety and awareness of the affected side. Use supervised scanning strategies and therapy guidance; adapt the environment to reduce falls.

Laterality: useful patterns, not absolute rules

A cerebral hemisphere stroke often causes weakness on the opposite side. Dominant-hemisphere injury, usually left, may cause aphasia. Right-hemisphere injury may cause left neglect and reduced awareness. Brainstem strokes can produce different or crossed patterns.

Prevent another stroke

Support prescribed BP and lipid management, diabetes care, smoking cessation, activity and medication adherence. Atrial fibrillation may require anticoagulation; its timing after stroke is individualised. Teach BE FAST and an emergency response even if symptoms resolve. [1-3]

References | Select to open

1. NINDS: Stroke Signs and Symptoms
2. Canadian Stroke Best Practices: Emergency Evaluation and Management
3. AHA/ASA: Acute Ischaemic Stroke Guideline (2026)
4. Canadian Stroke Best Practices: Swallowing, Nutrition and Oral Care
5. Canadian Stroke Best Practices: Intracerebral Haemorrhage