Cerebrovascular Accident (Stroke): Types, Signs and Nursing Care

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Quick answer: A cerebrovascular accident (CVA) is a stroke--a sudden injury to brain tissue caused by interruption of its blood supply or bleeding into or around the brain. The main categories are ischaemic stroke (blocked blood vessel) and haemorrhagic stroke (ruptured blood vessel). Stroke is an emergency: sudden symptoms require immediate activation of emergency services or the local stroke response pathway.

Related anatomy learning: For the structures and pathways affected by cerebrovascular events, see brain anatomy and the nervous system in our complete BS Nursing Anatomy and Physiology I & II guide.

Types of cerebrovascular accident

Ischaemic stroke

Blood flow to part of the brain is reduced or obstructed, usually by a thrombus or embolus. The affected brain tissue may become injured when oxygen delivery fails.

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Haemorrhagic stroke

A blood vessel ruptures and blood collects within the brain (intracerebral) or into the space around the brain (for example, subarachnoid haemorrhage).

Transient ischaemic attack (TIA)

Temporary neurological symptoms caused by transient cerebral ischaemia. Even if symptoms disappear, a TIA warrants emergency assessment because future stroke risk may be increased.

Stroke warning signs: FAST and BE-FAST

Simple recognition mnemonic

- B -- Balance: sudden difficulty walking, coordination loss or dizziness.
- E -- Eyes: sudden vision loss or major visual change.
- F -- Face: new facial droop or asymmetry.
- A -- Arms: new weakness or numbness, often affecting one side.
- S -- Speech: new slurred speech, difficulty speaking or understanding.
- T -- Time: immediately activate emergency response and record the last time the person was known to be well.

BE-FAST is a memory aid, not a screening tool that can exclude all strokes. A sudden severe unexplained headache or other acute neurological changes may also signal an

emergency.

Risk factors for stroke

Risk factors include hypertension, atrial fibrillation and other heart disease, diabetes, smoking, high cholesterol and previous stroke or TIA. Age and family history also matter. A risk factor is not proof of an active stroke, and absence of risk factors does not rule one out.

Stroke assessment: priorities for nursing students

- Recognise sudden neurological changes and activate the local emergency or stroke-alert pathway without delay.
- Note the symptom onset or the last known well time when available, and document who supplied it.
- Assess and support airway, breathing and circulation within professional scope; obtain required observations and bedside glucose as directed.
- Communicate findings succinctly, including the affected side, speech changes, baseline deficits, anticoagulant use if known, and accompanying symptoms.
- Follow authorised swallowing-safety precautions. Do not provide oral food, fluids or medications before appropriate swallowing assessment when stroke is suspected.

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Last known well vs time symptoms were discovered

Last known well is the last time the person was known to be at their usual neurological baseline. It is not automatically the time someone noticed the symptoms.

Fictional wake-up example: a partner confirms normal conversation and movement at 22:00. At 06:30, the patient wakes with new arm weakness and speech difficulty. Report both times and the partner as the information source; do not record 06:30 as a confirmed onset time. Activate the emergency response immediately. Uncertain timing is not a reason to delay assessment or assume treatment cannot help.

If baseline or timing is unknown, say so rather than estimating. See the NINDS definition of last-known-well time and stroke warning-sign guidance.

How is stroke diagnosed?

Urgent clinical assessment and brain imaging help distinguish bleeding from vessel occlusion; treatments differ and some therapies can be harmful in the wrong stroke type. Further assessment may involve blood tests, electrocardiography and vascular or cardiac imaging. Nurses should not independently label an acute stroke subtype based only on symptoms.

Stroke nursing care after the acute phase

Under a multidisciplinary plan, nursing care may include neurological observations, airway and aspiration-risk surveillance, skin integrity, mobility and falls prevention, communication support, nutrition and swallowing-safety planning, continence care, emotional wellbeing and rehabilitation participation. Reassess changes, patient goals and functional abilities continuously.

Worked scenario

An adult suddenly develops difficulty speaking and right arm weakness while eating lunch. The student nurse immediately seeks emergency assistance and follows the facility's stroke response procedure, obtains the last-known-well time from witnesses, observes breathing and other changes, and avoids giving oral intake pending assessment. Waiting to complete a routine neurological chart before escalating would be inappropriate.

Short questions and rationales

- What does CVA stand for? Cerebrovascular accident, commonly called a stroke.
- Which stroke is caused by a blocked artery? Ischaemic stroke.
- Which stroke involves a ruptured vessel? Haemorrhagic stroke.
- Can a TIA be ignored if symptoms resolve? No; it can precede a stroke and requires urgent evaluation.
- Why document last-known-well time? Timing guides emergency evaluation and eligibility decisions for time-sensitive treatments.

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Why must swallowing be screened before oral intake after stroke?

Stroke can impair swallowing and increase aspiration risk. A person being awake or asking for water does not establish safe swallowing. Follow the stroke pathway: an appropriately trained professional should screen swallowing before oral food, fluids or medicines, with further assessment when indicated. See NICE NG128.

Does a normal FAST check rule out every stroke?

No. Sudden balance or visual changes, severe unexplained headache and other acute neurological changes may also be concerning. A recognition mnemonic supports prompt action; it does not replace clinical assessment.

Related nursing learning

Read Semester 4 medical-surgical and neurological notes, neurological nursing assessment and ADPIE nursing care planning.

References

- NINDS: Stroke Overview.
- NINDS: Stroke Signs and Symptoms.
- NINDS: Assess and Treat.

Clinical caution: This is education, not an emergency treatment protocol. All suspected strokes require immediate local emergency response. Faculty and qualified clinical review pending.

Source: https://mynursinghub.com/cerebrovascular-accident-stroke-nursing/

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