

MODULE 5: NATIONAL INSTITUTES OF HEALTH STROKE SCALE (NIHSS)

Name: _____ Date: _____

1. Skilled and consistent use of a Standardized Nursing Assessment such as NIHSS may:
 - a. Positively impact patient outcomes
 - b. Lead to early intervention
 - c. Contribute to a better prognosis
 - d. Limit the extension of neurological damage
 - e. All of the above
2. Performing an NIHSS on a patient, once the nurse is familiar with it...
 - a. Should take 10 minutes or so to complete
 - b. Should take about an hour if the patient cooperates
 - c. Only needs to be done upon admission and again on discharge
 - d. Will show poor sensitivity to neurological change and Glasgow Coma Scale should be used instead

Quiz

- You may use the resource as a reference to answer these questions.
- Submit your completed quiz to the Nurse Clinician or designate for marking.

3. Communicate NIHSS results when:
- a. You notice a neurological **decline**
 - b. A **new** deficit has arisen
 - c. An already present deficit has **gotten worse**
 - d. You have a concern as the nurse that your patient
“is not quite right, compared to last night..”
 - e. All of the above

TRUE/FALSE Questions

(CIRCLE the correct letter)

- T** **F** 1. The NIHSS is designed to assess LOC or coma and measures best response in arousal and orientation.
- T** **F** 2. The lower the NIHSS overall total score, the more severe the stroke was.
- T** **F** 3. It is important **not to help** the patient answer the LOC questions.
- T** **F** 4. Only the upper quadrant is important when assessing the visual field.
- T** **F** 5. Mild paralysis such as asymmetry with a smile would score a 1 on the Facial Palsy question.
- T** **F** 6. Repeating words from the Standardized List on the NIHSS pocket card is the proper method to assess clarity of speech and detect presence of dysarthria.

SCORE: _____ / 9

Stroke Unit/Medical Unit Nurse Clinician/Designate

Signature