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 your binder as a reference to answer these questions
- Submit your completed quiz to the Nurse Clinician or designate for marking
- Your test will be returned to you to keep in your binder

SWO Stroke Network, 2014.
Adapted from NEO Stroke Network (2010).

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

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Signature