Triaging Acute Stroke

Patients with positive medical history and/or risk factors with the following symptoms and signs require *IMMEDIATE* assessment by the Triage Nurse or Charge Nurse for initiating the Stroke CCT:

PQRST Assessment

P rovocation of current illness, symptoms, precipitating factors
Q uality of symptoms
R egion/radiation of problem
S everity of symptoms
T ime of onset

Patient complaint of (HPI):

- ☐ Sudden numbness, weakness or paralysis of the face, arm or leg
- ☐ Difficulty in speaking or understanding simple statements
- ☐ Decreased vision or transient blindness in one eye
- ☐ An episode of double vision
- ☐ Unexplained dizziness, loss of balance or sudden falls
- ☐ Sudden, severe headaches with no apparent cause
- ☐ Duration of symptoms < 8 hours

PMH:

- ☐ Stroke/TIA/VBI
- ☐ Recent MI
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Recent head/necktrauma
- ☐ Valve prosthesis
- ☐ HTN
- ☐ DVT
- ☐ N/IDDM
- ☐ PVD
- ☐ Asthma/COPD
- ☐ Altered LOC
- ☐ SBE
- ☐ Thrombophlebitis
- ☐ Migraine H/A
- ☐ Wrestler
- ☐ Cocaine/crack use
- ☐ Chiropractor visit

Risk Factors:

- ☐ Obesity
- ☐ Family Hx
- ☐ High Cholesterol/Lipids
- ☐ Drug use: Coumadin/anticoagulants, birth control pills, noncompliance w/Rx
- ☐ ETOH/Substance Abuse: Cocaine, diet pills, smoking

Cranial nerves: eye signs/movements, speech musculature, protective reflexes

- ☐ Impaired Visual Acuity: impaired vision in one or both visual fields
  Have patient follow your finger to both sides; note when they can no longer see your finger
- ☐ Dysphagia:
  Have patient smile and assess for symmetry; any drooling, swallow reflex

Vital signs

Monitor: BP, pulse pressure, heart rate/rhythm, respirations, rectal temperature, carotid bruit
Observe for: Hypertension (especially SBP), alteration in respiratory pattern (Cushing's triad - SBP, ¯ HR, abnormal RR), A-fib
If recent head trauma: area(s) of ecchymosis/abrasions (Battle's/Raccoon signs); cerebrospinal fluid leaks (nasal discharge, ear)

Glasgow Coma Scale (assess and circle appropriate response)
Rule out hypoglycemia, intoxication, hypovolemia, hypothermia:

Eye Opening	*Spontaneous*	*4*	
	To Voice		*3*
	To Pain		*2*
	None		*1*
Best Verbal Response	*Oriented*	*5*	
	Confused, speaks but is disoriented		*4*
	Inappropriate but comprehensible words		*3*
	Incomprehensible sounds/unrecognizable words		*2*
	No sounds		*1*
Best Motor Response ***** refers to upper extremities only***	*Obeys command to move*	*6*	
	Localizes painful stimulus		*5*
	Withdraws from painful stimulus		*4*
	Flexion, abnormal decorticate posturing		*3*
	Extension, abnormal decerebrate posturing		*2*
	No movement, no posturing		*1*
TOTAL SCORE			________

(< 8 = major impaired consciousness, 9-12 = moderate impairment)

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This is a general guideline to assist in the management of patients.
This guideline is not designated to replace clinical judgment or individual patient needs.