

JOHN HUNTER HOSPITAL
 DIVISION OF EMERGENCY MEDICINE
STROKE/TIA -
TRIAGE, NURSING AND
MEDICAL ASSESSMENT

Q230 - JOHN HUNTER HOSPITAL
 MRN _____ Surname _____ Name _____
 Address _____
 DOB _____ Sex _____

TRIAGE ASSESSMENT

This assessment tool is intended for use with patients who have sudden onset of focal neurological

PRESENTING COMPLAINT: STROKE/TIA (FOCAL NEUROLOGICAL DEFICIT)

(Please use 24 hour clock time)

DATE: / / Time of Arrival: : Time of Triage: :

Interpreter required: Yes No Triage Priority: 1 2 3 4 5 Area: _____

Triage Assessment _____

	YES / NO	
FACE ABNORMAL	<input type="checkbox"/>	<input type="checkbox"/>
ARM ABNORMAL	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH ABNORMAL	<input type="checkbox"/>	<input type="checkbox"/>
LIKELY TIA	<input type="checkbox"/>	<input type="checkbox"/>

Allergies

Contact Person: _____

Phone Number: _____

General Practitioner: _____

GP Phone Number: _____

Triage Sign: _____

Print Name: _____

NURSING ASSESSMENT TIME OF ONSET OF SYMPTOMS (SELECT OPTION A, B, C, OR D):

	YES	DATE	TIME	Not Known
A: ACCURATE	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> : <input type="text"/>	<input type="checkbox"/>
B: APPROXIMATE	<input type="checkbox"/>	BETWEEN FOLLOWING TIMES:	<input type="text"/>	<input type="checkbox"/>
C: SLEEP	<input type="checkbox"/>	RETIRED TO BED:	<input type="text"/>	<input type="checkbox"/>
D: UNCERTAIN	<input type="checkbox"/>			<input type="checkbox"/>

THERAPY ELIGIBILITY

YES

ONSET TIME CLEARLY DEFINED AND < 3 HOURS	<input type="checkbox"/>
ONSET TIME < 6 HOURS	<input type="checkbox"/>
SCANDINAVIAN STROKE SCORE BETWEEN 10-40 (Assessment on page 4)	<input type="checkbox"/>

If patient potentially therapy eligible then an urgent CT should be performed (Level 1 Priority).

If patient therapy eligible page acute stroke team via John Hunter Hospital Switchboard (Ext: 13000)

Scandinavian Stroke Score: Please conduct assessment and place relevant score in the box. Please refer to page 4.

BLOOD TAKEN FOR - FBC, ESR, COAGS, UEC, GLUCOSE: RN ATTENDED

POTENTIAL ADMISSION - LIAISE WITH STROKE TEAM

Registered Nurse: _____
 (please print name)

Signature: _____

Designation: _____

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_____	_____

MEDICAL ASSESSMENT

MEDICAL OFFICER: _____

TIME OF ASSESSMENT: :

CHECK TIME OF ONSET; IF INCORRECT
ENTER NEW TIME OF ONSET:

:

Please use 24 hour clock time

REASON FOR CHANGE _____

HISTORY OF PRESENTING ILLNESS

History of recent head injury? YES NO

If recent head injury and altered level of consciousness consider subdural haemorrhage and CT Priority One.

PAST HISTORY

Stroke TIA IHD PVD Hypertension Diabetes High Cholesterol AF

MEDICATION / DRUG HISTORY

Medications

Allergies

Cigarettes (Pack Years) **ETOH** grams/day

SOCIAL / FAMILY HISTORY

EXAMINATION

General Appearance: _____

Pulse _____ BPM Respiratory Rate _____ resps / minute SpO2 _____ %

Temperature _____ BM or BSL _____ mmol/L Atrial Fibrillation

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PROBLEM LIST

INITIAL MANAGEMENT PLAN

It is recommended that non-contrast CT brain scanning be performed as early as is practical after the patient arrives in hospital with a stroke syndrome.

CT PRIORITY GUIDELINES Please tick appropriate CT priority level

Level 1 = "Immediate" = CT needed within 1 hour

- possibility of associated head trauma
- impaired or deteriorating level of consciousness
- clinical suspicion of an expanding posterior fossa lesion (cerebellar signs, lower cranial nerve palsy, coning)
- clinical suspicion of subarachnoid haemorrhage

CT REQUESTED: Time :
 Date / /

Level 2 = "Urgent" = CT needed within 4 hours

- full anticoagulant therapy considered appropriate by senior medical staff
- expanding intracranial aneurysm suspected
- moderate to severe acute stroke syndrome
- Scandinavian Stroke Scale of < 40

CT PERFORMED: Time :
 Date / /

Level 3 = "Semi-urgent" = CT within same day

- minor stroke syndromes
- transient ischaemic attacks
- stable acute deficit for 24 hours or longer
- Scandinavian Stroke Scale of > 40

RESULTS
ICH Yes No

CT Scan not currently indicated
 Reason why: -----

CONSISTENT WITH ACUTE INFARCTION Yes No

OLD INFARCTION Yes No

OTHER Yes No

CT to be arranged as an outpatient

If patient therapy eligible then an urgent CT should be performed (Level 1 Priority).

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Neurologically stable since arrival	<input type="checkbox"/> YES If NO Discuss with the Stroke /Medical Team <input type="checkbox"/> NO
Swallowing status	<i>Initial swallowing assessment completed</i> <input checked="" type="checkbox"/> <input type="checkbox"/> if YES <input type="checkbox"/> if NO → <input type="checkbox"/> NBM <input type="checkbox"/> Medications but no other oral ingestion <input type="checkbox"/> Awaiting speech pathology assessment <input type="checkbox"/> Diet as per Medical Team
Hydration/feeding plans	NBM or medications only by mouth Ensure 60ml/hour either IV or NG unless concern about CCF or CRF <input type="checkbox"/> Intravenous fluids - 60-80 ml/hr (Avoid iv glucose in diabetics or when BSL>11mmol/l) <input type="checkbox"/> Nasogastric tube for fluids or feed if oral medications need to be given
Blood sugar (formal) Aim for 7 - 11 mmol/l	<i>If BSL >11 mmol/l</i> <input checked="" type="checkbox"/> <input type="checkbox"/> if YES <input type="checkbox"/> Stat short acting insulin (dose depending on initial BSL) and consider insulin infusion (in consultation with ED specialist) <i>If</i> <input type="checkbox"/> 7-11 mmol/l → Q6H BSL <i>If</i> <input type="checkbox"/> <3mmol/l → consider administration of 50% glucose iv
Body temperature Aim for < 37.5 celsius	<i>If temperature >= 37.5</i> <input type="checkbox"/> if YES <input type="checkbox"/> >37.5 oral or rectal paracetamol 1g Q6H <input checked="" type="checkbox"/> <input type="checkbox"/> >38.0 - paracetamol 1g Q6H plus septic workup
Positioning issues	Optimise patient safety <input type="checkbox"/> Impaired consciousness - coma position <input type="checkbox"/> Visual or sensory neglect - support for neglected side and prevention of physical injury to neglected side <input type="checkbox"/> Hemiparesis - support for hemiparetic shoulder
Education & Support <input checked="" type="checkbox"/>	<input type="checkbox"/> Liaison with stroke case manager <input type="checkbox"/> Liaison with on call social worker <input type="checkbox"/> Verbal information & relevant stroke brochures provided to patient/family

POSSIBLE ACUTE STROKE THERAPY PATIENT Yes No

POTENTIAL ADMISSION Yes

Patient referred to Neurology/General Medicine Yes No

SEPARATION FROM EMERGENCY DEPARTMENT (Please tick the relevant box)

- Admission Admit Stroke Unit Admit General Medical Ward Discharge Home
 Neurovascular Clinic Review GP Follow Up Death Other

Medical Officer Signature: _____
 (Please Print)
Name: _____ **Designation:** _____

PLEASE NOW COMPLETE APPROPRIATE MANAGEMENT PLAN DOCUMENT

Referrals to Neurovascular Clinic - Page 5538 (Office Hours) or ring Ext: 13481 Anytime

