PATIENT DETAILS FORM

Affix patient sticker here

PATIENT NAME:

Patient identity number/passport number

Date of birth Gender M F

Medical aid name

Dependant code

Medical aid number

Next of kin, name

Next of kin, contact number

Address

REGISTERED NURSE PROTOCOL
INCLUDING TRIAGE

PATIENT NAME:

Objective: Confirm diagnosis of stroke and perform initial physical evaluation in under 10 minutes

Stroke screening[1,2]

	Normal	Abnormal
☐ Facial droop	Both sides of face move equally	Unequal movement of the face
☐ Arm drift	Both arms move equally or not at all	One arm drifts compared to the other
☐ Speech	Patient uses correct words with no slurring	Slurred or inappropriate words or mute

☐ Suspected stroke diagnosed

☐ **Activate code stroke[2]**

Time of arrival at hospital	Time called	:	Time present	:
Time of first medical contact	Time called	:	Time present	:
Inform stroke team	Time called	:	Time present	:
Inform radiology	Time called	:	Time present	:
Inform clinical laboratory	Time called	:	Time present	:

Time from symptom onset:[5]

☐ < 4,5 hours ago
☐ > 4,5 hours ago
☐ Unknown

Co-morbidities

Carry out the following orders as appropriate:

☐ Immediate transfer to Radiology if arrival within 4,5 hrs from onset[3]
☐ Check blood sugar by finger stick[4,5] mmol/L
If < 2,78 mmol/L or > 22,2 mmol/L, inform doctor immediately
☐ Start on O_2 (2 - 4 l/min nasal canulla, to keep SpO_2 > 94 %)[2,4]
☐ Establish IV access and start normal saline infusion [3]
☐ Determine patients weight kg
☐ Perform 12-lead ECG
☐ Connect to continuous cardiac monitoring[3]

Vital signs to be monitored[3] (q15min for 2h, q30min for 6h, q30min for 3h, q1h for 16 hours)

☐ Blood pressure	mmHg
☐ Heart rate	bpm
☐ Cardiac rhythm	
☐ SpO_2	
☐ Temperature	
☐ Respiratory rate	
☐ Peripheral pulses	
☐ Gaze & pupil size	

Notify Pathology to draw blood for the following laboratory studies[4]

- ☐ Full blood count and platelet count (FBC)
- ☐ Serum urea and electrolytes (U+E)
- ☐ Blood glucose
- ☐ C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)
- ☐ Liver function test (LFT)
- ☐ Pregnancy test (if applicable)
- ☐ **Warfarin** **Yes** ☐ **No** ☐
  - INR
- ☐ **NOACS** **Yes** ☐ **No** ☐
  - Fibrinogen
  - PTT Test
  - Prothrombin time
  - Hemoclot

Essential checklist to follow:[33]

Yes	No	
☐	☐	Incline head of bed at 30°.
☐	☐	Notify doctor if SBP > 180 - 185 mmHg or DBP > 110 - 105 mmHg.
☐	☐	If indicated insert urinary catheter before starting rt-PA (this should not delay the initiation of rt-PA).
☐	☐	No IM injections in the first 24 hours.
☐	☐	Apply pressure dressing on any failed vein puncture sites.
☐	☐	Avoid nasogastric tubes if possible for 24 hours.
☐	☐	Keep NPO until the swallowing screen has been done. If dysphagia present keep NPO. Do screen ASAP.
☐	☐	Perform neurological examination (SNOBS) every 15 mins during tPA administration.
☐	☐	Doctor at bedside for first hour.

Nurse, Name	Signature	Date
		Time

References: 1. Kothari R, Hall K, Brott T et al. Early stroke recognition: Developing an out-of-hospital NIH stroke scale. Academic emergency medicine 1997;(4):986-990. **2.** Bryer A, Connor MD, Haug P et al. South African guideline for management of ischaemic stroke and transient ischaemic attack 2010: A guideline from the South African Stroke Society (SASS) and the SASS writing committee. South African Medical Journal 2010; 100(11):750.778. **3.** Summers D, Leonard A, Wentworth D et al. Comprehensive overview of nursing and interdisciplinary care of the acute ischemic stroke patient. A scientific statement from the American Heart Association. Stroke 2009;40:2911-2944. **4**. The European Stroke Organisation (ESO) Executive Committee and the ESO Writing Committee. Guidelines for management of ischaemic stroke and transient ischaemic attack 2008. Cerebrovascular Disease 2008;25:457–507/update 2009. **5.** Jauch EC, Saver JL, Adams HP et al. Guidelines for the early management of patients with acute ischemic stroke: Executive Summary. Stroke 2013;44:870–947. BI Ref No: GPM-STK-0051-ZA.