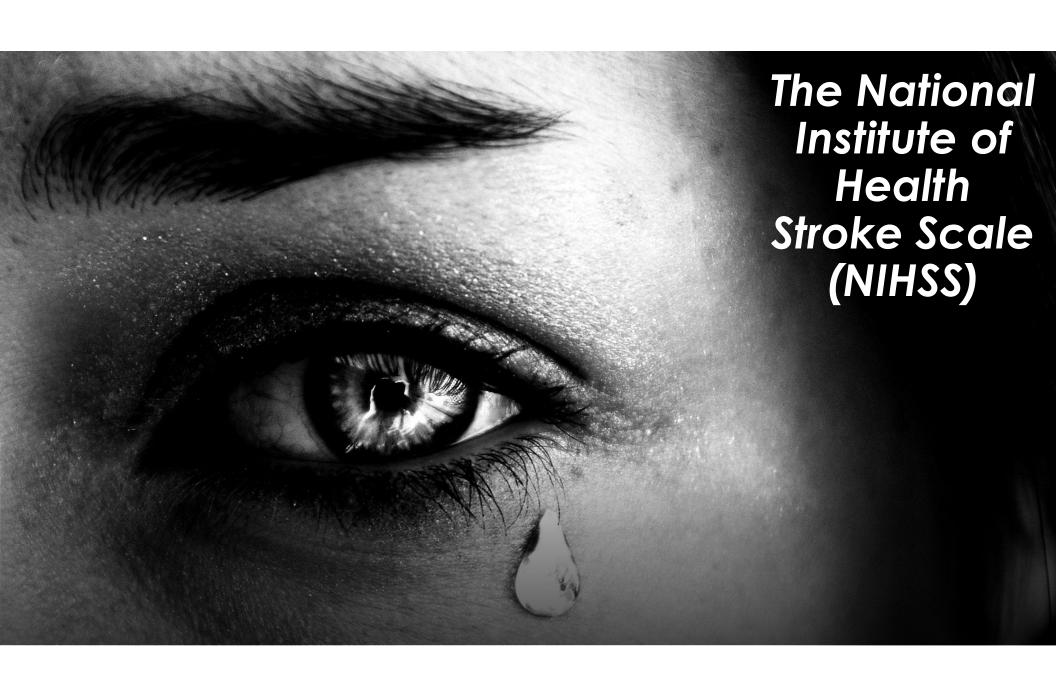
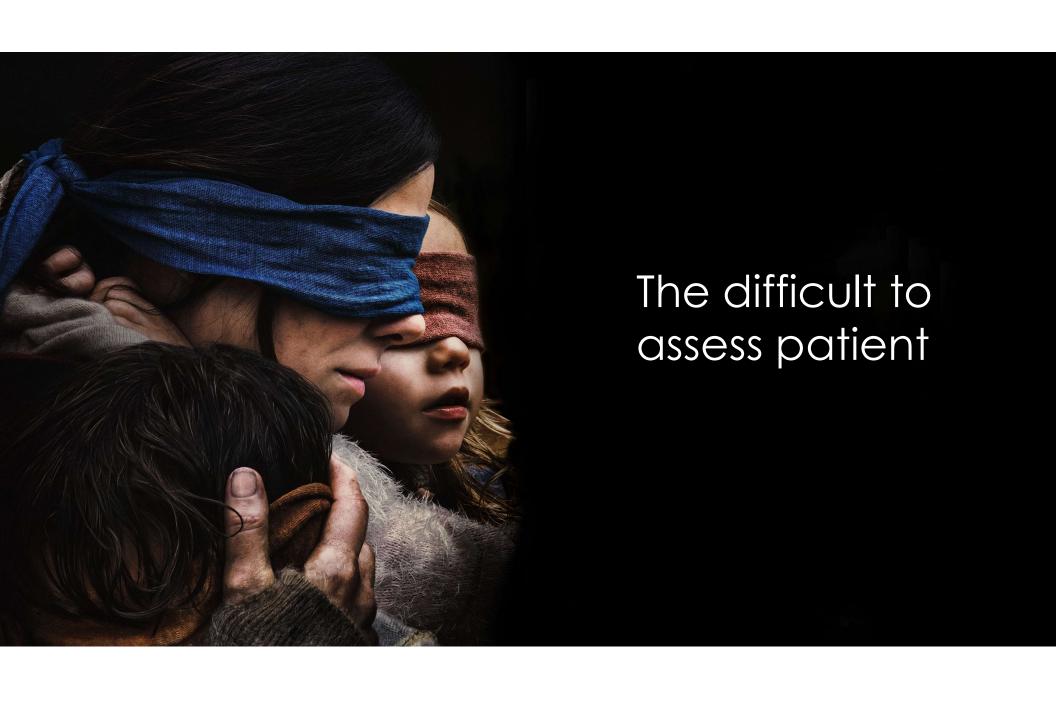
DEBUNKING THE MYTH OF "UNABLE TO ASSESS"

LIZ SALYERS, MS, AGACNP-BC, SCRN







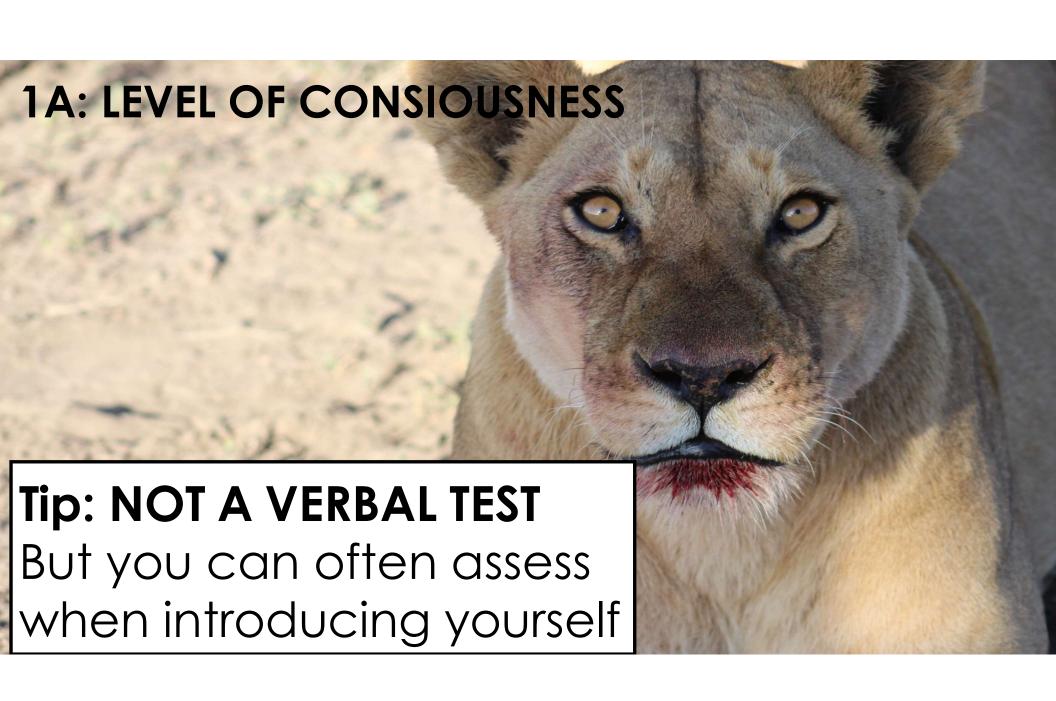


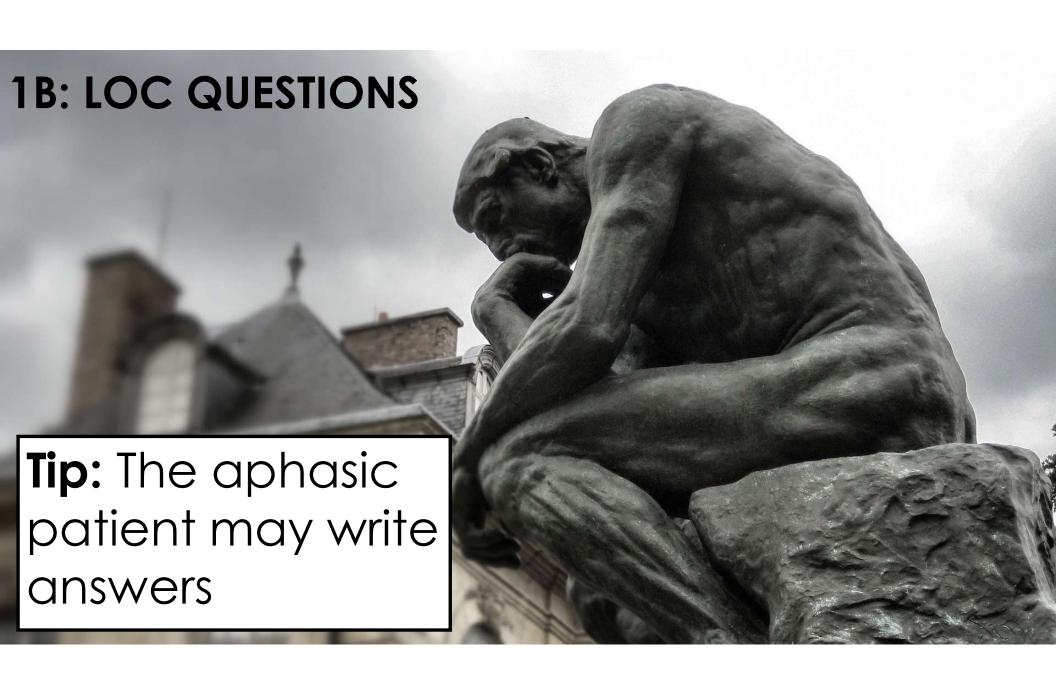


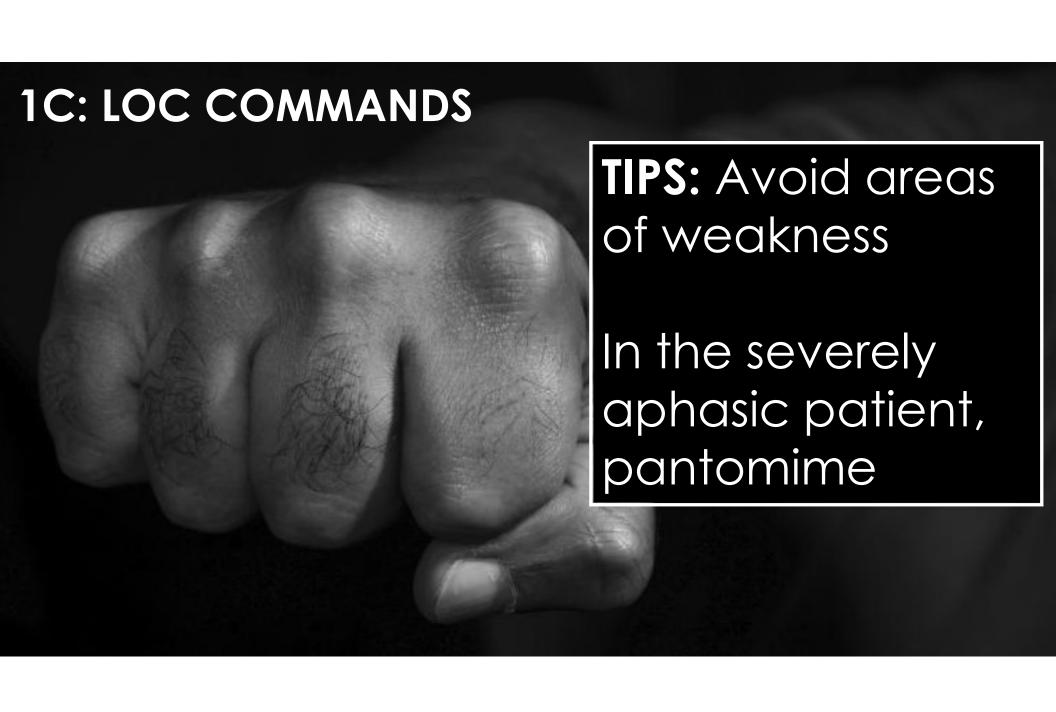


Score the patient on what they CAN DO, not what you think they can do







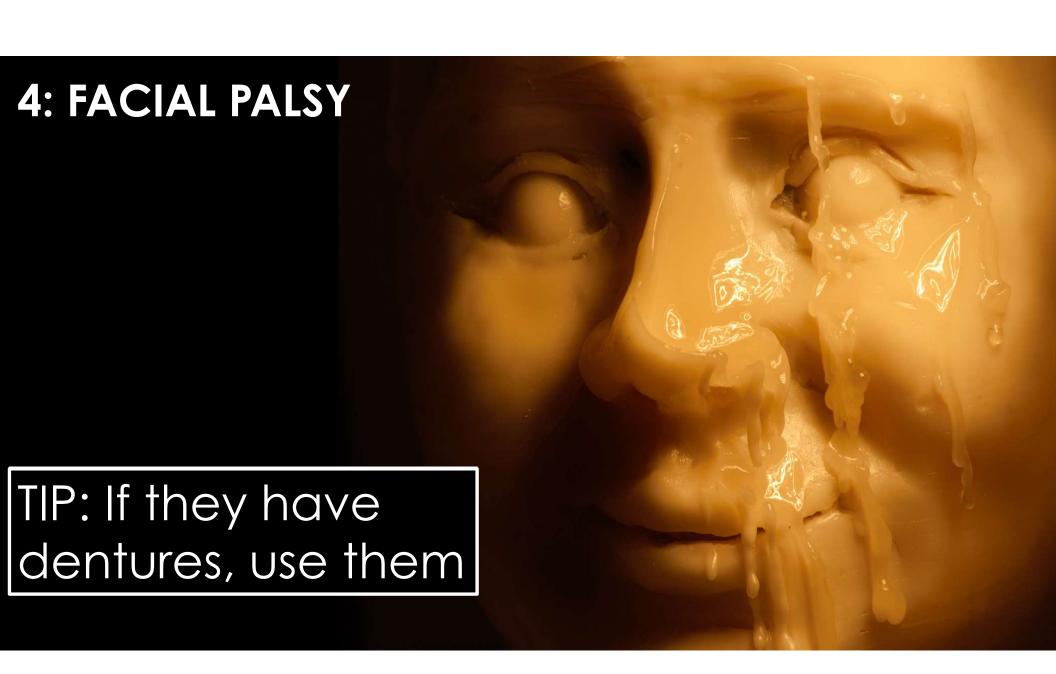




"Doll's Eyes" aka Oculocephalic Reflex







5/6 A&B: MOTOR



TIPS: You CAN encourage your patient!

Make sure limb is placed within visual field

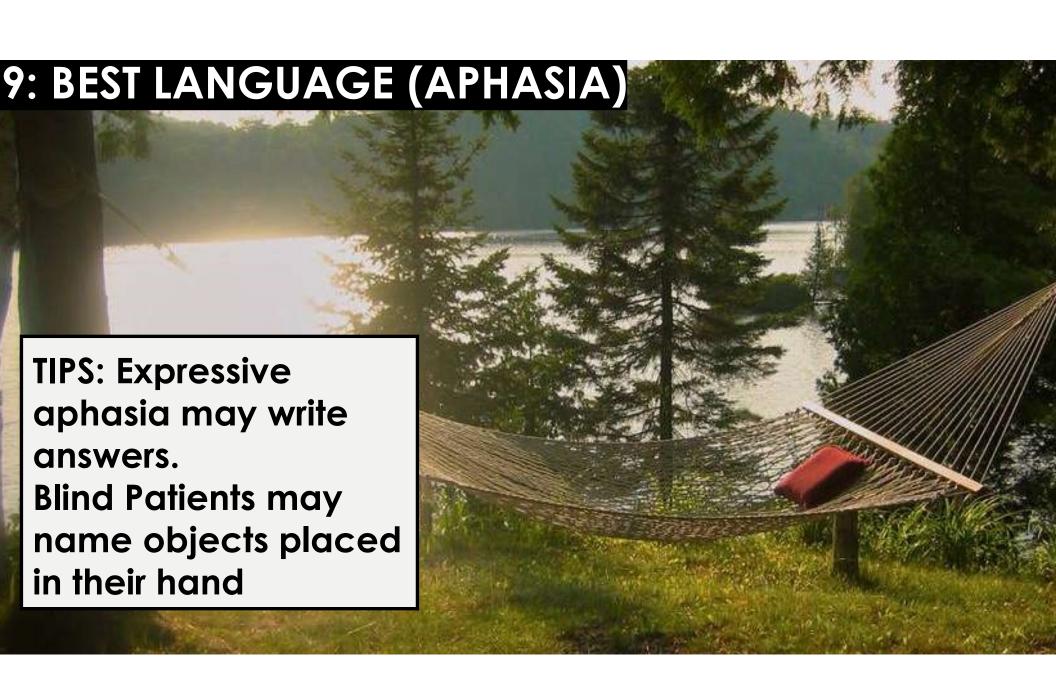


8: SENSORY

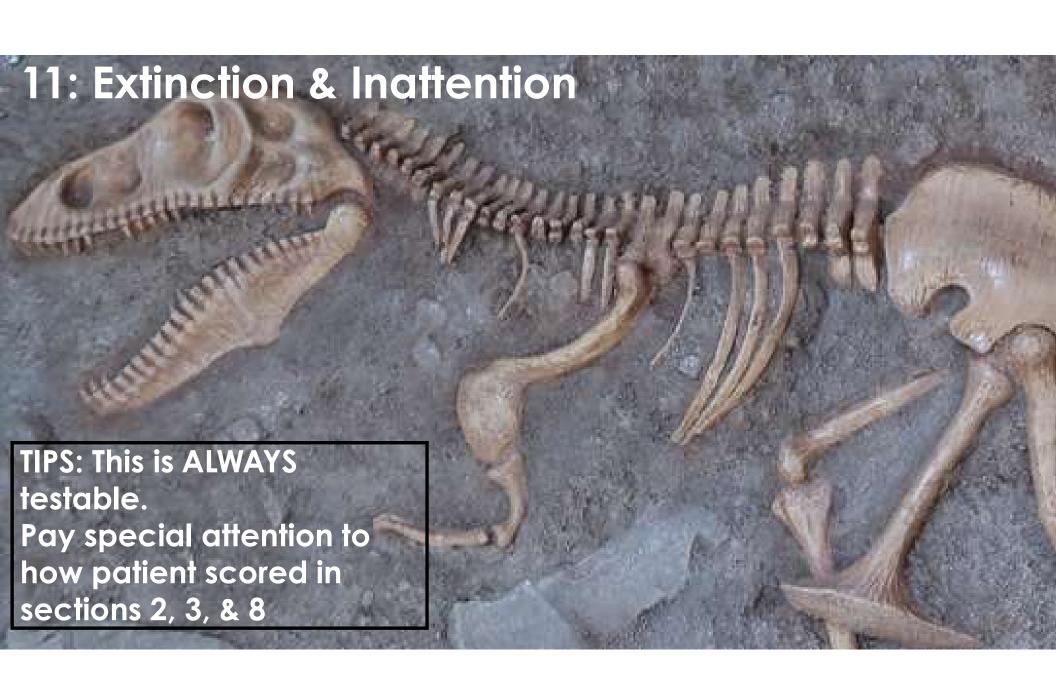
TIPS:

- •Test multiple areas of the extremity for accuracy
- Avoid the hands and feet











- NIHSS is a skill
- Bedside nurse handoff NIHSS
- Post treatment mNIHSS warnings
- Know your institutions expectation on deviation/changes in scores
- Never chart "UNABLE TO ASSESS" on any stroke patient for NIHSS assessments

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