SECTION D: PSYCHOLOGICAL ADAPTATION
CHAPTER 16: Physical Assessment

POLICY AND PROCEDURE 16.2: Neurological Assessment

PURPOSE: Neurological status is assessed to detect the presence of neurological abnormalities and/or to screen for changes in a patient's neurological function over time. This policy provides registered nurses at WFH with a uniform procedure for which to assess a patient's neurological status. A standardized focused neurological exam form is included along with the notification requirements of any abnormal findings.

POLICY: **Whiting Forensic Hospital's Nursing Executive Committee** has reviewed and approved the resources contained in *Nursing Reference Center* relating to the Neurological Assessment of a patient. Click on the link below to review Nursing Practice and Skill.
Note: any policy information that is specific to Whiting Forensic Hospital will be displayed in the HOSPITAL SPECIFIC SECTION.

HOSPITAL SPECIFIC:

1. **Flow Sheet and Assessment:** The *Neuro Assessment Flow Sheet* may be initiated by a Registered Nurse or a Medical Staff Provider; however, it must be discontinued by a Medical Staff Provider in the Physician's Order section of the medical chart. Patients who fall and hit their head or have an unwitnessed fall will have the following assessment schedule:

Vital Signs and Neuro Assessment status post fall:

every	**15**	**mins.**	**X**	**(1) hour, then**
every	**30**	**mins.**	**X**	**(1) hour, then**
every	**1**	**hour**	**X**	**(4) hours, then**
every	**4**	**hours**	**X**	**(24) hours**

NOTE: *Progress along this time schedule* ***ONLY*** *if all neurological signs are stable*

2. **Documentation**
   Neurological assessment and documentation on the flow sheet shall include:
   a. Date and time of assessment
   b. Eye opening
   c. Verbal response
   d. Motor response
   e. Pupillary response
   f. Limb response

3. **Initialing and Legal Signature**
   The assessing Registered Nurse shall initial each documentation entry. When utilizing the flow sheet for the first time, the nurse shall record his/her full legal signature and classification in the space provided on the bottom of the form.

4. **Pertinent Changes and Interventions**
   The nurse shall document and report any pertinent changes in the patient's neurological status immediately to the ACS Clinician or covering Medical Staff Provider. Any follow-up interventions initiated as a result of the assessment should be noted on the 24 hour Nursing Inter-shift Report.

5. **Medical Record and Obtaining Forms**
   The *Neuro Assessment Flow Sheet* shall remain a permanent part of the patient's medical record and filed in the Integrated Progress Notes section of the chart.

PROCEDURE:

RESPONSIBLE PARTY	ACTION
Medical Provider **OR** Attending Psychiatrist **OR** On-Call Psychiatrist	1. Writes order for neurological assessment.
Registered Nurse	2. Initiates neurological assessment.
Registered Nurse	3. Places *Neuro Assessment Flow Sheet* in the patient's chart.

Registered Nurse	4. Explains procedure to patient and instructs them to report any symptoms. Symptoms could include: • Blurred vision • Headache • Drowsiness • Vomiting • Slurred speech • Weakness or paralysis • Numbness or tingling 5. Assesses patient's neurological status every 4 hours for 24 hours, unless ordered more or less frequently by the medical provider.
Registered Nurse	6. Documents the following on the Neuro Assessment Flow Sheet *(WFH-695):* a. Eye opening b. Verbal response c. Motor response d. Pupillary response e. Limb response 7. Dates, times, and initials each assessment. Signs full legal signature in the space provided when initialing flow sheet for the first time. 8. Notifies Medical Staff Provider of any pertinent changes in patient's neurological status; documents any interventions as well as their effectiveness on the 24 hour Nursing Inter-shift Report. 9. Assess patient's neurological status per ordered frequency or as indicated by patient's condition.

NEUROLOGICAL ASSESSMENT: GENERAL CONSIDERATIONS
Reference: CINAHL Nursing Guide, July 24, 2015