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:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Assessment Interval</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>every 15 mins.</td>
<td>X</td>
<td>(1) hour, then</td>
</tr>
<tr>
<td>every 30 mins.</td>
<td>X</td>
<td>(1) hour, then</td>
</tr>
<tr>
<td>every 1 hour</td>
<td>X</td>
<td>(4) hours, then</td>
</tr>
<tr>
<td>every 4 hours</td>
<td>X</td>
<td>(24) hours</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>RESPONSIBLE PARTY</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Provider OR Attending Psychatrist OR</td>
<td>1. Writes order for neurological assessment.</td>
</tr>
<tr>
<td>On-Call Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2. Initiates neurological assessment.</td>
</tr>
</tbody>
</table>
| 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. | 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**  