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| NEUROLOGIC CHECK | | | | NO. | |
| PURPOSE:  To assure that residents who have any type of head injury, falls with head injury or un- witnessed falls have no sign or symptoms of neurologic impairment.  STATEMENT OF POLICY:  Residents who have a fall involving striking the head or un- witnessed falls where it is not apparent if head injury occurred will have neurologic checks done by the nurse in charge of their care. The only exception would be if the resident is alert and oriented and has no evidence of head injury and denies hitting the head.  PROCEDURE:   1. ASSESSMENT PROCEDURE. 2. Obtain equipment to be used in neurologic checks including penlight, gloves and neurologic check documentation form. 3. Perform hand washing 4. Become familiar with general physical assessment and history of neurologic disorders and conditions affecting baseline mental status. 5. Assess vital signs, temperature, pulse, respirations blood pressure, 0z saturation, B.S. if indicated. 6. Check orientation via verbal responses to questions regarding name, place, person, date, time, and events, attention span, mood affect and behavior. 7. Check ability to respond to verbal commands, raise arms, close eyes, move in bed. 8. Check response to tactile stimuli, squeeze hand, apply pressure to arm or leg on both sides of body. 9. Check eyes for size and shape and ability to open and close; note symmetry of both eyes, compare pupil size to chart and equality. 10. Use a penlight to check response to pupils to light, direct light from outer to inner aspect of eye and note constrictions, dilation when the light is removed; compare both eyes for equality, constriction and dilation (PERL) 11. Check eye movement by noting ability to follow finger with eyes in all directions, ability to focus on finger while moving it towards nose. 12. Check ability to open and close eyes, presence of ptosis of lid. 13. Check eye movements on unconscious resident by moving the head to the side with eyes open and note that the eye will move in opposite direction of the rotation (dolls eyes) and by moving head up and down and note that the eye movement will be in the opposite direction. 14. Check grip of hand and ability to squeeze a hand and compare strength in both hands. 15. Check strength in both arms and legs by having resident close eyes and extend arms out in front with palms up and raise legs one at a time and push down on them; arms that drift down indicate muscle weakness. 16. Note any spontaneous movement if resident is unconscious to check motor strength or note any resistance to range of motion exercises. 17. Note muscle tone, motor gait, tremor, or tingling in extremities. | | | | | |
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| NEUROLOGIC CHECK | | | | NO. | |
| 1. Monitor for change in neurologic checks and notify physician of all changes. 2. FREQUENCY OF NEUROLOGIC EXAMINATIONS. 3. First group of neurologic checks will be done at 15 minute intervals times 4. 4. Second group of neurologic checks will be done at 30 minute intervals times 4. 5. Third group of neurologic checks will be done at 1 hour intervals times 4. 6. Fourth group of neurologic checks will be done at 4 hour intervals times 4. 7. Fifth group of neurologic checks will be done at each shift intervals times 4. 8. Sixth group of neurologic checks will be continued at each shift intervals through 72 hours 9. DOCUMENTATION AND INTERVENTIONS 10. Document results of neurologic checks on the Briggs form # CFS6-19HH per the policy. 11. Document additional nurses notes for any abnormal finding and notify the physician of these findings for intervention. 12. Continue documentations for the full 72 hours after the fall of head injury incident. | | | | | |
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