HealthCap
RISK MANAGEMENT SERVICES

IDENTIFICATION OF NEUROLOGICAL DEFICITS

Policy & Procedure

Certified nursing assistants often play an integral part in assisting with neurological examinations. It is recommended that a licensed nurse and certified nursing assistant perform neurological exams together.

A thorough nursing assessment may uncover nervous system dysfunction before injury occurs. Whether it is a brief check of neurological status or a comprehensive neurological exam, it is essential that the facility policy and procedure clearly identify the expectations of each caregiver.

Policy Considerations:

1. Licensed nurse performs a thorough neurological assessment on all residents involved in an un-witnessed fall.

2. Signs and symptoms of a head injury may include the following. If any of these symptoms are observed by a certified nursing assistant, it should be immediately reported to a licensed nurse:
    a. Unusual drowsiness or lethargy (difficult arousing);
    b. Mental confusion;
    c. Slurred speech;
    d. Nausea and forceful or repeated vomiting;
    e. Stiff neck;
    f. Fever;
    g. Seizure activity;
    h. Unequal pupils, papillary response or accommodation;
    i. Clumsy walking, stumbling or other problems with use of extremities;
    j. Numbness or parasthesia (sensation of tingling, prickling or numbness of skin);
    k. Headache (mild or severe);
    l. Dizziness;
    m. Double vision or blind spots;
    n. Increased blood pressure or a marked drop in blood pressure;
    o. Decrease in pulse and/or increased and shallow respirations (possible intracranial pressure); and/or
    p. Unequal grasp and/or non-existent extremity movements (possible cerebral damage).

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3. If a resident is observed on the floor, the resident should not be moved until an initial assessment has been performed. An initial assessment should include:
    a. Providing as much privacy as possible;
    b. Evaluating the resident's level of consciousness and mentation. A change in the level of consciousness can be a heralding sign that the resident's condition is deteriorating.
    c. Assessment of pupil reaction, blood pressure, temperature, pulse, respirations, grasp and active range of motion of all extremities.
    d. If neck or spinal injury is suspected, the resident should be kept still until first responders are on site.

4. Following the initial assessment, providing the resident is able to be moved, the following should be completed:
    a. Checking orthostatic blood pressures per facility protocol.
    b. Conducting neurological assessments per facility policy and/or as indicated by the medical director or attending physician.

5. Subsequent assessments should focus on the nervous system areas identified as "out of the normal range" during the initial assessment timeframe.

6. Each subsequent assessment should be compared to the results of any previous assessment as this will enable the assessor to identify any changes and intervene timely.

7. The attending physician should be notified immediately of any signs of deterioration in the resident's status post-incident.

This guideline has been developed to assist your facility in establishing a policy and procedure to address suspected head injury. It is not intended to serve as a policy however the key elements to establishing an appropriate policy are included.

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I have read, understand and agree to adhere to the requirements outlined in this policy and procedure.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____ _____ _____ _____ _____

This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.