K-130 Neuro Assessment

Purpose

Adequately determine the level of consciousness.

Screen for the presence of sensory or motor impairment.

Evaluate cognitive and behavioral elements of the physical examination.

Applies To

Registered Nurses

Licensed Practical/Vocational Nurses

Other (*Identify*): _____

Equipment/Supplies

- Blood pressure cuff and stethoscope.
- Penlight or flashlight.
- Safety pin.

Procedure

1. Assess whether the client is taking any pain medication or central nervous system depressants or other medications that could influence findings.
2. Screen for symptoms such as headaches, dizziness, visual disturbance, weakness, dysphasia or sensory-perceptual impairment.
3. Explain the procedure to the client.
4. Measure temperature, pulse, respirations and blood pressure.
5. Assess the client's level of consciousness by asking questions and determining the appropriate response.
6. Determine the client's orientation by response to day, date, time, and place and person.
7. Check sensory function:
    a. Have the client close his/her eyes.
    b. Ask the client to voice when dull or sharp sensation is felt by alternate applications of the pointed and blunt ends of a pin to the skin.
8. Assess motor function by observing gait, equality of hand grasps, and equality of leg/foot resistance.
9. Assess pupillary reaction:
    a. Dim room lights.
    b. Have the client look straight ahead.

c. Move penlight from the side of the client's face and direct the light on the pupil.

d. Observe pupillary response of both eyes and measure the size in millimeters.

e. Inspect the eyelids for drooping.

f. Assess facial symmetry.

g. Document findings in clinical record.

Related Procedures

None

Policy History

Approval Date Approved By	11/1/2009 Anne Tyson, Herman Pippin, Sandra Hill
Revision Date Approved by	12/31/2009 Anne Tyson, Herman Pippin, Sandra Hill
Revision Date Approved by	
Revision Date Approved by	