

## ADMINISTRATIVE POLICY

### 1 NEURO STATUS ASSESSMENT AND USE OF THE NEURO STATUS FORM:

1.1 Any time an individual has an injury to the head or suspected injury to the head, either by a blow to the head or by falling and striking the head, regardless of whether they receive medical attention or not, a Neuro Assessment needs to be done. Many times when a person sustains a head injury there are no immediate signs or symptoms of internal injury. A person who has sustained a head injury or suspected head injury needs to be assessed very carefully over the next 24 hours to see if any signs/symptoms occur. An internal head injury can be slow to develop, but can be deadly. If the individual was taken to the Emergency Room or to see a physician, generally there will be instructions for after-care given. Those instructions are to be followed in conjunction with this assessment form. If there is a conflict, follow the doctors orders and/or call your supervisor or on-call.

1.2 The person with a suspected head injury should be assessed every hour for 12 hours, then every two hours after that for the next twelve hours. If seen by an M.D., they may have different frequency orders. Call the supervisor/on-call for directions. The following areas, as noted on the Neuro Status Form are to be checked:

Time: Put the exact time that the check was done and not when it was supposed to be done. The exact time is important.

Pupils: Pupils are normally equal in size and constrict to light equally. This is what is meant by PERL – pupils equal and reactive to light. When someone has a serious head trauma the right and left pupils will not always be equal in size, nor will they react equally to light. Sometimes the pupil will be sluggish in reacting – sometimes it won't react at all. This must be checked in a fairly dark room by using a flashlight. If they react normally, simply put PERL, otherwise note the non-reactive pupil or that they are not equal. If there is a “non” normal response, double check your results, if they are still unequal or unresponsive, call 911 then call the nurse or supervisor immediately.

Orientation: People can become disoriented if they have a head injury. This assessment is based also on the individual's usual level of functioning, so the answers may be simply a change from the usual or may not be able to be assessed – mark "n/a". You need to actually ask the person if they know who they are – say their name; where they are – at home, SLO; the time – can be the hour, or more usually, the day. If they know these, just mark: O.K. If they

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do not know, and they normally would know, again, call the nurse or supervisor immediately. If there are really large changes, call 911 first.

**Mobility/Strength:** Sometimes the way the signs/symptoms appear is in strength and coordination. By asking the person to “squeeze” your hand using each hand separately, you can assess if there is a difference in strength from one side to the other. Watching them walk you can determine how their balance and leg strength is – again usually strength and mobility needs to be considered. If they are complaining of being dizzy, call the supervisor or on-call. Simply mark: O.K. if their strength, gait and balance appear as usual. If there is a change, immediately notify the nurse or supervisor. Again, if there are really great differences, call 911.

**Pain:** Pain can show up in various places after a head injury. You need to ask if they are having any pain. Where and how intense is important, also has it increased from the initial hit. Mark the space with what they report to you. If the quality of the pain has changed substantially or if they complain about increasing intense pain, call the nurse or supervisor immediately.

**Bleeding from the Ear:** If a person begins to bleed from either ear after a head injury and they did not cut or bruise the ear during the initial injury, call 911 immediately then call the nurse or supervisor and inform them.

**Sudden Uncontrollable Vomiting:** If a person begins to vomit or vomits more than they did, call 911 immediately then call the nurse or supervisor and inform them.

**Convulsion:** If the individual does not have a seizure disorder and they have a seizure (generally of the Grand Mal type), call 911 Immediately then call the nurse or supervisor and inform them.

- 1.3 These are guidelines. If for any reason you are not comfortable with what is occurring with the person, call the supervisor or the on-call.
- 1.4 Initial each entry and be sure that your signature and corresponding initials are at the bottom of each sheet.

POLICY DATE: April 2002  
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