Neuro Assessment

Mental Status:

1. Does the patient arouse upon entering the room?
2. If they don't, how do you or can you get them to respond? Is it to touch or only to painful stimuli, or not at all?
3. Assess orientation by asking name, DOB, where they are, a current event everyone should know.

Speech: When asking these questions, you are noting is the patient's speech clear and appropriate? Or is it garbled?

Cranial nerves:

1 **Olfactory**: how might we test smell?

2 Optic: visual fields (tests peripheral vision) and acuity.

Visual fields- Where the patient is seated in front of you looking directly at your nose and you bring something into their PERIPHERY and they tell you when they can see it by saying yes. If a patient has problems with cranial nerve 2 in seeing things in their periphery, what are they at risk for? What interventions might you employ to decrease this risk?

Visual acuity- Snellen chart. This is detect vision most often used in eye offices. If one is not available and you wanted to test this, what could you use?

3,4,6 Occulomotor, Trochlear, Abducens: Tested together as they all participate in eye movement

- This is where you do PEARRLA however, the optic nerve, cranial nerve 2 must be intact for this reflex to occur.
- Cardinal fields of vision: pt. should parallel track object with eyes. This can be done by having the patient follow your finger to each of the six locations.

If your patient's eyes jerk while attempting to follow your finger, what do you call that?

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5 Trigeminal: having patient close their eyes, see if they can identify a light touch from a cotton wisp or something sharp such as a pin prick.

-Since we are testing sensation, you could also assess for recognition of hot and cold. You may hear of people utilizing test tubes of hot and cold water to assess this by placing them to the cheek of the patient with their eyes closed. In the hospital setting, what could you use to emulate this?

-Have patient clench teeth and feel the muscles surrounding the jaw. Should feel strong and symmetrical

7 Facial: this is where the patient raises his or her eyebrows; can smile and frown. Looking for symmetry of the muscles.

8 Vestibulocochlear: have patient close eyes and see if they can hear the rustling of your fingers or paper moving together. Not normally tested

9, 10 Glossopharyngeal, Vagus: tongue blade for gag reflex.

-can be done with a less alert patient. To do this touch the side of the posterior soft palate with a tongue blade

- For an alert patient, have him or her open mouth and say "ah" noting bilateral symmetry of the soft palate.

11 Accessory: ask patient to shrug shoulders and/or turn head from side to side against resistance. Here we are noting symmetry and atrophy of muscle.

12 Hypoglassal: This is where the patient sticks the tongue out and moves from side to side and up and down. Can utilize resistance of the tongue blade.

If you watch videos and read resources, you will notice there are many different takes on the neuro assessment. For a bedside neuro assessment, the most important thing is to be consistent. Keep to a particular order to ensure that 1. You don't miss something and 2. It will be easy to detect abnormalities.

Also, keep it patient specific and always ensure you are charting per your facility's policy.

We will also be discussing later the Glascow Coma Scale (GCS) as well as the NIH Stroke Scale (NIHSS). FRMC does include a version of the GCS in their Meditech Neuro Assessment, but the NIHSS is utilized during stroke alerts and is done by a trained ICU nurse.