	Montana Mental Health Nursing Care Center **Policy Manual**	**Policy Number**	**541**
		Original Date	**10/24/1995**
		Revised Date	**07/10/2014**
	Department: Nursing		
	Neuro Assessment		

PURPOSE:

To assess a resident who has sustained an injury to the head, or when a resident has fallen and the fall was not observed. (Unless the resident is cognitively alert and states they did not hit their head).

PROCEDURE:

1. Monitor neuro signs, pulse, respirations, and blood pressure every hour x 2, then every 2 hours x 2 and then every 4 hours x 2.

2. Monitor temperature with initial assessment, then every 8 hours (once per shift) unless abnormal, then monitor every 4 hours until stable x 24 hours.

3. Notify medical physician if resident has visible head trauma, if neuro assessment is abnormal or is in question, or if there is any change in resident's condition.

4. Document summary of incident, resident's condition and any information given to physician in nurse's notes.

5. Complete incident report.

6. Include neuro assessment findings in daily report to each shift until neuro assessment is completed.

7. When neuro flow sheet is completed, place form in resident chart under graphics. (Attachment #1)