6.12: Checklist for Neurological Assessment

Begin assessing a patient's general appearance, posture, ability to walk, personal hygiene, and other general survey assessments during the first few minutes of the initial nurse-patient interaction. When asking the patient to perform specific neurological tests, it is helpful to demonstrate movements for the patient. Explain the purpose and use of any equipment used.

Use the checklist below to review the steps for completion of a routine “Neurological Assessment.”

Steps

Disclaimer: Always review and follow agency policy regarding this specific skill.

1. Gather supplies: penlight. For a comprehensive neurological exam, additional supplies may be needed: Snellen chart; tongue depressor; cotton wisp or applicator; and percussion hammer; objects to touch, such as coins or paper clips; substances to smell, such as vanilla, mint, or coffee; and substances to taste such as sugar, salt, or lemon.

2. Perform safety steps:
   a. Perform hand hygiene.
Check the room for transmission-based precautions.

Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.

Confirm patient ID using two patient identifiers (e.g., name and date of birth).

Explain the process to the patient and ask if they have any questions.

Be organized and systematic.

Use appropriate listening and questioning skills.

Listen and attend to patient cues.

Ensure the patient’s privacy and dignity.

Assess ABCs.

3. Obtain subjective assessment data related to history of neurological disease and any current neurological concerns using effective communication.

4. Assess the patient’s behavior, language, mood, hygiene, and choice of dress while performing the interview. Note any hearing or visual deficits and ensure glasses and hearing aids are in place, if needed.

5. Assess level of consciousness and orientation; use Glasgow Coma Scale if appropriate.

6. (Optional) Complete Mini-Mental State Examination (MMSE), if indicated.

7. Assess for PERRLA.

8. Assess motor strength and sensation.
   - Hand grasps
   - Upper body strength/resistance
   - Lower body strength/resistance
   - Sensation in extremities

   - Ask the patient to walk, using an assistive device if needed, assessing gait for smoothness, coordination, and arm swing.
   - As appropriate, assess the patient’s ability to tandem walk (heel to toe), walk on tiptoes, walk on heels.
   - Assess cerebellar functioning using tests such as Romberg, pronator drift, rapid alternating hand movement, fingertip-to-nose, and heel-to-shin tests.

10. (Optional) Perform a cranial nerve assessment and assess deep tendon reflexes as indicated.

11. Assist the patient to a comfortable position, ask if they have any questions, and thank them for their time.

12. Ensure five safety measures when leaving the room:
   - CALL LIGHT: Within reach
   - BED: Low and locked (in lowest position and brakes on)
   - SIDE RAILS: Secured
   - TABLE: Within reach
   - ROOM: Risk-free for falls (scan room and clear any obstacles)

13. Perform hand hygiene.

14. Document the assessment findings and report any concerns according to agency policy.