MRAD 202 – Patient Care 2

Neurological Assessment & Physical Evaluation of a Patient

Physical Evaluation is an ongoing process of **observation, assessment and measurement** to note and evaluate any changes in the patient's condition. Sometimes referred to as "eyeballing."

A skilled observer will compare the actions and appearance of the patient to one they have seenbefore.

Physical Evaluation includes assessing:

- Skin colour
- Skin temperature
- Breathing
- Level of consciousness (LOC)

1. SKIN COLOUR
    a. Easiest way to recognize change.
    b. Look for cyanosis (bluish color in the skin).
    c. Caused by lack of oxygen in the tissues.
    d. Easily seen on mucous membranes such as lips and lining of the mouth.
    e. If a patient looks pale and anxious and states they "do not feel well," the technologist should NOT leave the patient.

2. SKIN TEMPERATURE
    a. Contact through touch also allows ongoing physical observation.
    b. Acutely ill patient who is in pain is likely pale, cool and diaphoretic (i.e., cold sweat).
    c. Hot, dry skin may indicate a fever, while moist skin may only be a response tothe environment.

3. BREATHING
    a. Changes may signal onset of serious distress.

b. **Normal** breathing is quiet and calm.
c. **Abnormal** breathing is audible, wheezing, gasping or coughing.
d. Sudden onset of **rapid**, **shallow** breathing is usually first sign of respiratory distress.

4. LOC is noted to establish patient's baseline
    a. Alert and responsive
    b. Drowsy but responsive
    c. Unconscious but reactive to painful stimuli
    d. Comatose

Are the patient's eyes open and focused? Does the patient look at you when you speak? Dothey respond appropriately? Ask them an open-ended question.

When communicating with a patient who is drowsy or in a stupor, remember this:

1. **They can't be relied upon to remember instructions.**
2. **They are not responsible for their actions or answers.**

Any patient with a decreased LOC must be kept under close observation. Intoxicated patientsmay appear to have just "passed out," but close monitoring of their LOC in still important because the alcohol may obscure important symptoms.

Note: Make no statement in front of the unconscious patient you wouldn't make if they wereawake.

Glasgow Coma Scale

A scale used to assess LOC and reaction to stimuli in a neurologically impaired patient basedon performance in 3 categories:

1. **Eye opening** – Score 1–4
2. **Verbal response** – Score 1–5
3. **Motor response** – Score 1–6

The scores are assessed individually and as a sum of the three. The **highest possible score is 15.** Lower scores predict poorer outcomes.

A change in the Glasgow Scale could be caused by an increase in intracranial pressure (ICP).This change can be life-threatening and a physician must be notified immediately.

Signs of increased intracranial pressure:

- Patient becomes irritable
- Patient becomes lethargic
- Patient's pulse slows down and their rate of respiration decreases.

See notes on Glasgow Coma Scale (Table 16.1) in Ehrlich & Coakes, 2016, p. 289.

Patient's Physical Environment includes:

- Temperature
- Humidity
- Lighting
- Ventilation
- Colour of surroundings
- Noise

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