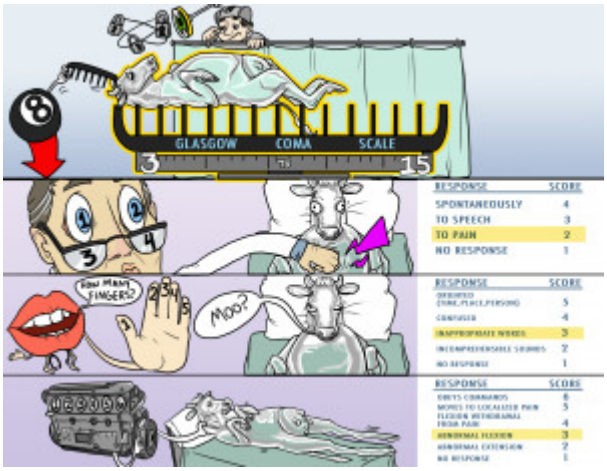
Glasgow Coma Scale

The Glasgow Coma Scale (GCS) is a standardized system for quickly assessing level of consciousness and is often used to determine the severity of an acute brain injury. It comprises three mini assessments of the patient that are each given a score. Spontaneous Eye Response (1 to 4 points), Verbal Response (1 to 5 points), and Motor Response (1 to 6 points). These three categories are each given a score, which is then summed to a maximum score of 15. Easily remember Eyes, Verbal, Motor, and correlate to 4+5+6, when you add them together you get a perfect total 15.



PLAY PICMONIC

LOC Assessment

Lock-halo Assess-man

The GCS allows for a quick assessment that can be documented in the patient record or provided to another healthcare provider to easily assess the patient's level of consciousness.

Score of 3 to 15

Scale from 3 to 15

The total GCS score is the sum of the numeric values assigned to each category assessed. A score of 15 is the highest awarded to a fully alert person; the lowest possible score is 3. A GCS score of less than 8 often indicates coma.

8 or Less = Coma

Down-arrow (8) Ball holding a Comb

Any patient who has a score of less than 8 is considered comatose, if they do not have communication impairment like being deaf or blind or debilitating muscular disease. Remember to assess your patients fully!

Eye Opening

Eyes Open

Eye opening is rated 1 to 4 points. Examples of how to rate eye opening: If your patient is spontaneously moving their eyes (4). You have to say something to your patient for them to open their eyes (3). You have to painfully stimulate them to open (2) and they do not open their eyes no matter what you do (1). 4 = spontaneous response, 3 = to voice, 2 = to pain, 1= none.

Verbal Response

Verbal-mouth

Verbal response is rated 1 to 5 points. Examples of how to rate verbal response: They participate in conversation and are oriented to time, place, and person (5). They are speaking understandably but some words are slurred or sluggish and they may seem disoriented (4). They think they are speaking but it isn't understandable (3). They only speak in sounds or grunts (2). They are completely mute, even with a painful stimulus (1). 5 = normal conversation, 4 = disoriented conversation, 3 = words, but not coherent, 2 = no words, only sounds, 1 = none.

Motor Response

Motor

Motor response is rated 1 to 6 points. Examples of how to rate motor response: They are moving limbs normally with no pain (6). With a painful stimulus, such as a trapezius pinch, the patient brings a hand above the clavicle to the site of physical stimulus (5). With a painful stimulus, the patient displaying normal flexion (e.g. rapid, variable, away from body) without abnormality in movement (e.g. slow stereotyped, rotation of forearm, leg extends with painful trapezius stimulus) is withdrawing in response to pain (4). If they have decorticate posturing which is curling of the limbs towards the spinal cord or “towards dee cord” as we sometimes say (3). If they have decerebrate posturing which is curling of the limbs away from the spinal cord (2). And lastly, if they have no motor response (1). 6 = normal, 5 = localized to pain, 4 = withdraws to pain, 3 = decorticate posture, 2 = decerebrate posture, 1 = none.