EVENT MEDICINE
EDUCATION PLANNING OPERATIONS

GLASGOW COMA SCALE
ASSESSMENT GUIDE

A structured approach using Best Practices

Use of the Glasgow Coma Scale (GCS) requires the application of four steps: check, observe, stimulate, rate.

Check for factors that may limit or impact on the assessment, such as eye injury, hearing impairment, sedation, or existing paralysis.

Observe the patient's eye, verbal, and motor responses to determine if they are spontaneous and normal.

Stimulate the patient verbally. If the patient does not respond, provide physical stimulation using pressure.

Rate the patient using all three components of the GCS, awarding the best score achieved in each section.

EYES

4	Spontaneous	If the patient's eyes are open, and they visually engage with activities in front of them, their eye-opening is Spontaneous.
3	To Sound *(Voice/Verbal)*	If the patient only opens their eyes when you introduce yourself and ask them to open their eyes, their eye-opening is To Sound. Shouting may be necessary.
2	To Pressure *(Pain)*	If the patient opens their eyes only after the application of physical peripheral pressure stimulus, their eye-opening is To Pressure. Correct application of pressure stimulus is by peripheral pressure. Place a pen across the tip of the nailbed then press down with increasing intensity for up to 10 seconds or until a patient responds, whichever occurs first.
1	None	The patient does not open their eyes at all.
NT	Not Testable	If there are injuries to the eyes or other pre-existing conditions that preclude the patient from opening their eyes, you should consider eyes as Not Testable.

VERBAL

5	Oriented	Ask the patient to tell you their name, where they are, and the name of the current month. If they can answer all three questions correctly, they are Oriented (to person, place, and time).
4	Confused	If the patient answers the person, place, and time questions in full sentences, but gives incorrect answers, they are Confused.
3	Words *(Inappropriate)*	If the patient does not talk sensibly but uses single words out of context, their verbal response is Words.
2	Sounds *(Incomprehensible)*	If the patient moans and groans but does not use clear, comprehensible words, their verbal response is Sounds.
1	None	If the patient makes no sounds at all.
NT	Not Testable	If a patient is unable to speak due to pre-existing conditions, consider Verbal as Not Testable.

MOTOR

6	Obey Commands	The patient is required to perform a two-step action. First, ask the patient to reach out and grasp your hand with their hand by crossing the midline. Ensure this request includes both parts: (1) reaching out and extending their arm, and (2) the squeezing of your hand with their hand. Avoid placing your hand in their hand or close to them as to result in only a single step action. The request to cross the midline may require additional instructions to ensure the patient uses the arm furthest away from you. For example, when standing to the patient's left, ask: "can you use your right arm to reach out and squeeze my hand". If there are limiting factors to using an arm or both arms, adapt the test accordingly, or you can ask the patient to open their mouth and stick out their tongue as a last resort.
5	Localizing	If the patient does not obey commands, a pressure stimulus is required. Begin with a central stimulus. Perform a trapezius squeeze (trapezius pinch) by applying pressure with increasing intensity for up to 10 seconds or until a patient responds, whichever occurs first. Another location to perform central pressure stimulation is the supraorbital notch unless the patient has facial injuries. Use of sternal rub can result in bruising and assessing the patient's motor response can be difficult to interpret. Applying pressure behind the jaw can also be hard to interpret or apply accurately between care providers. If the patient moves their hand above the clavicle to in the direction of the pressure stimulus, they are Localizing.
4	Normal Flexion *(Withdrawing)*	If the patient moves based on the trapezius squeeze but does not lift their hand above the clavicle, perform a nailbed tip pressure stimulus. If the elbow bends and the hand moves away from the pressure stimulus, the patient is responding with Normal Flexion.
3	Abnormal Flexion *(Decorticate)*	If the patient flexes their elbow towards their body with slow arm movement across the body, they are responding with Abnormal Flexion.
2	Extension *(Decerebrate)*	If the patient extends their elbows and straightens their arms, the patient is responding with Extension.
1	None	A patient makes no response to verbal or physical stimulus.
NT	Not Testable	If a patient is unable to move due to factors such as sedation or previous paralysis, they are Not Testable.

If the patient responses vary from one side of the body to the other, record the better side's response.