

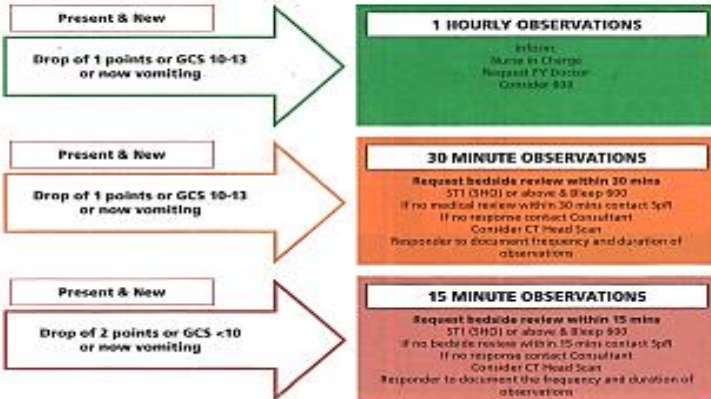
Neurological Observation Chart

Glasgow Coma Scale (GCS) (Corp/Proc/719)

A set of general observation must be carried out with every set of neurological observations. Observe for vomiting. Carry out a Blood glucose check on initiation and act on the results if abnormal. (Corp/Proc/570)

Criteria	Observed	Rating	Score
Eyes Opening	Open before stimulus	Spontaneous	4
	After spoken or shouted request	To sound	3
	After fingertip stimulus	To pressure	2
	No opening at any time, no interfering factor	None	1
	Eyes closed by local factor	Non testable	NT
Score			
Verbal Response	Correctly gives name, place and date	Orientated	5
	Not orientated but communication coherent	Confused	4
	Intelligible single words	Words	3
	Only moans/groans	Sounds	2
	No audible response, no interfering factor	None	1
Factor interfering with communication	Non testable	NT	
Score			
Best Motor Response	Obeys simple command e.g. make a fist	Obeys commands	6
	Localising to painful stimulus	Localising	5
	Withdrawal to painful stimulus	Flex limb away	4
	Pressure on nail bed causes abnormal flexion of limbs	Recoil response to pain	3
	Painful stimulus causes limb extension	Extension to response to pain	2
	No movement in arms/legs, no interfering factor	No response to pain	1
Paralysed or other limiting factor	Non testable	NT	
Score			
Total GCS			
Pupils	Size (mm) R		
	Reaction +/-		
	Size (mm) L		
	Reaction +/-		
Print Initial			
Counter Sign			

NEUROLOGICAL OBSERVATION ESCALATOR Actions Required



If a patient sustains a Head Injury OR Has a fall with a Head or Facial Injury, or has an unwitnessed fall

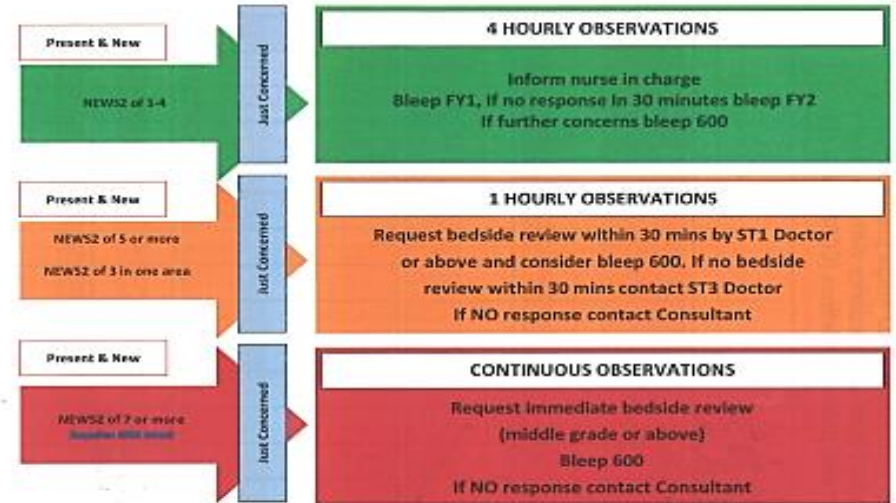
Neurological observations must be carried out as below:

Every 15 minutes for 2 hours
Followed by every 30 minutes for 4 hours
Followed by every hour for 24 hours
until the patient is stable and medically reviewed or there is a documented instruction by a senior medical/trial care colleague conferring a reduction in frequency.

Should the patient deteriorate from their baseline GCS OR they postural vital signs at any time, please seek urgent medical review.

Refer to **CONVULSIONS, Falls Management and Falls Risk Assessment Procedure** for further guidance

NEWS2 ESCALATOR Actions Required



If new changes to AVPU score consider neurological observations

ADULT CARDIAC ARREST/MEDICAL EMERGENCY CALL 2222

THINK SEPSIS

Does your patient have two or more of the following?

Raised respiratory rate

New confusion

Fall in blood pressure $\geq 40\text{mmHg}$ from baseline

YES?

Consider the possibility of sepsis and seek immediate medical review.

Be prepared to achieve the 'Sepsis Six' within 1 hour:

1. Give oxygen if required to achieve target SpO2
2. Take blood cultures
3. Give antibiotics
4. Consider IV fluid bolus
5. Take bloods to include serum lactate
6. Hourly fluid balance and urine output

(Trust Sepsis Pathway 2018)

Remember the sepsis pathway

THINK KIDNEYS

Provide adequate hydration for all patients and ensure effective fluid balance monitoring of all 'at risk' patients including:

Patients over 65

Diarrhoea & vomiting

Diabetes

Feeding and nutrition support

Heart failure

Recovery from critical illness

Surgical, chest and ascitic drains

IV fluids

Nephrotoxic medication

Drop in blood pressure of more than 30mmHg **

Recent surgery

** this is not an exhaustive list

If the target urine volume is not met you **must** seek medical review.

(Corp/Proc/627)

Remember the acute kidney injury pathway