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/670)

Date/Month				
Time (24 hour clock)				
Observation Monitoring Frequency				
Criterion	**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	Obey simple command e.g. make a fist	Obeys commands	6	
	Localising to painful stimulus	Localising	5	
	Withdrawal to painful stimulus	Pulls limb away	4	
	Pressure on nail bed causes abnormal flexion of limbs	Flexor 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

Present & New

Drop of 1 points or GCS 10-13 or now vomiting

→ **1 HOURLY OBSERVATIONS**

Inform:
Nurse in Charge
Request FY Doctor
Consider 833

Present & New

Drop of 1 points or GCS 10-13 or now vomiting

→ **30 MINUTE OBSERVATIONS**

Request bedside review within 30 mins
ST1 (SHO) or above & Bleep 600
If no medical review within 30 mins contact SpR
If no response contact Consultant
Consider CT Head Scan
Responder to document frequency and duration of observations

Present & New

Drop of 2 points or GCS <10 or now vomiting

→ **15 MINUTE OBSERVATIONS**

Request bedside review within 15 mins
ST1 (SHO) or above & Bleep 600
If no bedside review within 15 mins contact SpR
If no response contact Consultant
Consider CT Head Scan
Responder to document the frequency and duration of observations

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 2 hours
until the patient is stable and medically reviewed or there is a documented instruction by a senior medical/critical care colleague confirming a reduction in frequency.

Should the patient deteriorate from their baseline GCS OR their pupil size alter at any time, please seek urgent medical review.

Refer to CORP/PROC/668 Falls Management and Falls Risk Assessment Procedure for further guidance

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NEWS2 ESCALATOR
Actions Required

Present & New

NEWS2 of 1-4

Just Concerned

→ **4 HOURLY OBSERVATIONS**

Inform nurse in charge
Bleep FY1, If no response in 30 minutes bleep FY2
If further concerns bleep 600

Present & New

NEWS2 of 5 or more

NEWS2 of 3 in one area

Just Concerned

→ **1 HOURLY OBSERVATIONS**

Request bedside review within 30 mins by ST1 Doctor or above and consider bleep 600. If no bedside review within 30 mins contact ST3 Doctor
If NO response contact Consultant

Present & New

NEWS2 of 7 or more

Just Concerned

→ **CONTINUOUS OBSERVATIONS**

Request immediate bedside review (middle grade or above)
Bleep 600
If NO response contact Consultant

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 ≥ 40mmHg 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 Recent surgery	*Drop in blood pressure of more than 30mmHg **

*** 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