

GLASGOW COMA SCALE

at a Glance



The Glasgow Coma Scale (GCS) is used to assess the level of consciousness in non-intubated patients 13 years and older.

- ✓ Assess each component
- ✓ Add the scores
- ✓ Document
- ✓ Reassess and compare trends

EYE OPENING RESPONSE (E)	
SCORE	RESPONSE
4	Spontaneous Opens eyes without stimulus
3	To Voice Opens eyes when spoken to
2	To Pain Opens eyes to pain
1	None Does not open eyes



VERBAL RESPONSE (V)	
SCORE	RESPONSE
5	Oriented Alert and oriented to person, place, time, and situation
4	Confused Disoriented conversation, but able to answer questions
3	Inappropriate Words Uses words, but not appropriate to situation
2	Incomprehensible Sounds Moans, groans, or incomprehensible speech
1	None No verbal response



MOTOR RESPONSE (M)	
SCORE	RESPONSE
6	Obeys Commands Follows verbal commands
5	Localizes Pain Purposeful movement to painful stimulus
4	Withdraws from Pain Withdraws or pulls away from painful stimulus
3	Abnormal Flexion (Decorticate) Flexes arms/hands to painful stimulus
2	Abnormal Extension (Decerebrate) Extends arms, adducts thumbs to painful stimulus
1	None No motor response




TOTAL SCORE INTERPRETATION	
TOTAL GCS SCORE	SEVERITY OF BRAIN INJURY
13 – 15	Mild Injury Generally alert to drowsy
9 – 12	Moderate Injury Variable level of consciousness
3 – 8	Severe Injury Coma Consider airway protection

⚠ Lower scores indicate more severe injury and higher risk for complications.

CALCULATE THE SCORE	
Add the three components:	
E (1–4)	+
V (1–5)	+
M (1–6)	
= TOTAL GCS SCORE	
RANGE: 3 – 15	

EXAMPLE:
E 3 + V 4 + M 6 = 13
 Interpretation: Mild Injury

NURSING PRIORITIES	
	Assess trends, not just one score. Compare with previous assessments.
	Document each component separately. (e.g., E3 V4 M6)
	Report any decline in score promptly.
	Protect the airway when indicated, especially with severe neurologic impairment.
	Reassess regularly and after any change in condition or intervention.

IMPORTANT REMINDERS	
✓	Use ONLY for patients 13 years and older.
✓	Do NOT use if intubated or unable to speak.
✓	Medications, sedation, intoxication, or metabolic conditions can affect the score.
✓	Always assess safety, airway, breathing, and circulation first.

★ BEST PRACTICE	
A change of 2 or more points in the GCS is significant and should be reported.	

GCS QUICK REFERENCE	
EYE OPENING (E)	1 – 4 points
VERBAL RESPONSE (V)	1 – 5 points
MOTOR RESPONSE (M)	1 – 6 points
TOTAL GCS SCORE: 3 – 15 POINTS	



Glasgow Coma Scale — Quiz

1. The nurse assesses a patient who opens the eyes when spoken to, is confused but able to answer questions, and obeys verbal commands. What GCS score should the nurse document?
 - A. 11
 - B. 12
 - C. 13
 - D. 14
2. A patient's GCS was 13 during the previous assessment and is now 11. What is the nurse's priority action?
 - A. Report the change promptly
 - B. Reassess the patient at the end of the shift
 - C. Document only the new total score
 - D. Continue routine assessments because the score remains above 8
3. During assessment, a patient does not open the eyes, makes incomprehensible sounds, and withdraws from painful stimulation. What is the patient's GCS score?
 - A. 6
 - B. 7
 - C. 8
 - D. 9
4. Which documentation by the nurse provides the most complete information about a patient's Glasgow Coma Scale assessment?
 - A. GCS indicates moderate injury
 - B. Neurological status unchanged
 - C. GCS 13
 - D. GCS 13: E3 V4 M6
5. A patient flexes the arms and hands in response to painful stimulation. How should the nurse score the patient's **motor response**?
 - A. 2
 - B. 3
 - C. 4
 - D. 5



Glasgow Coma Scale — Clinical Unscramble

Use the sentence clue to unscramble each nursing term.

1. Opens the eyes without stimulation. SSOETAOUNNP

Answer: _____

2. Alert and oriented to person, place, time, and situation. OEITENRD

Answer: _____

3. Follows verbal commands appropriately. BOSYE SNMDOACM

Answer: _____

4. Purposefully moves toward a painful stimulus. ALLZECOIS PNIA

Answer: _____

5. Pulls away from a painful stimulus. IWDARWHTLA

Answer: _____

6. Abnormal flexion of the arms and hands in response to pain. ETRCTODIAEC

Answer: _____

7. Abnormal extension of the arms in response to pain. EDEAETERCRB

Answer: _____

8. This neurologic assessment evaluates eye, verbal, and motor responses. ASWGGLO OMCA
LCSAE

Answer: _____



Word Search

Find the words in the grid

L	O	D	R	D	T	Y	R	O	W	I	B	O	N	N	I	G	I	L	D	R	E
T	A	E	Y	X	Q	S	F	A	I	M	N	R	N	I	L	T	N	N	E	A	C
S	P	O	N	T	A	N	E	O	U	S	N	I	N	A	A	E	C	I	C	W	D
D	E	A	A	G	I	E	T	C	R	X	E	I	S	P	R	I	O	E	E	I	S
E	E	O	R	S	L	X	A	V	E	N	R	G	E	S	G	S	M	X	R	O	O
T	T	C	E	A	N	E	A	I	Q	A	O	S	M	E	C	M	P	C	E	T	N
N	R	E	O	H	E	I	R	E	E	W	A	T	T	Z	L	I	R	A	B	I	L
E	A	S	A	R	S	S	E	B	C	L	T	E	C	I	T	T	E	G	R	G	T
I	O	N	I	N	T	Q	N	O	A	G	O	Y	I	L	R	E	H	I	A	S	B
R	R	O	T	Y	E	I	M	O	J	A	R	G	C	A	E	O	E	E	T	S	R
O	L	P	E	L	A	A	C	C	P	M	G	D	I	C	E	I	N	O	E	E	E
I	Z	S	R	O	S	E	I	A	M	S	S	T	T	O	R	T	S	A	A	S	A
I	S	E	M	C	S	Y	E	T	T	S	E	H	T	L	E	E	I	E	O	S	N
A	I	R	A	P	N	E	W	T	S	E	V	R	Z	E	A	E	B	N	E	A	D
N	A	L	S	E	E	O	X	N	R	B	X	T	R	E	R	C	L	S	I	E	L
E	E	A	J	N	R	P	N	I	A	O	I	R	K	O	A	S	E	P	S	R	D
A	I	B	E	O	E	E	P	A	I	N	F	U	L	S	T	I	M	U	L	U	S
O	P	R	P	I	M	N	H	E	O	Z	D	I	T	E	A	O	F	I	F	T	C
C	C	E	A	R	T	I	S	W	A	R	D	H	T	I	W	N	M	D	L	B	O
E	J	V	A	E	L	N	N	I	I	C	N	E	U	R	O	L	O	G	I	C	M
T	O	X	R	I	L	G	T	T	A	D	S	T	D	C	I	L	T	M	T	T	W
N	S	D	N	A	M	M	O	C	S	Y	E	B	O	M	R	E	N	A	S	I	H

**GLASGOW COMA SCALE • EYE OPENING • VERBAL RESPONSE • MOTOR RESPONSE
• SPONTANEOUS • ORIENTED • CONFUSED • INCOMPREHENSIBLE • OBEYS
COMMANDS • LOCALIZES PAIN • WITHDRAWS • DECORTICATE • DECEREBRATE •
PAINFUL STIMULUS • NEUROLOGIC • REASSESS**

Take AIM and Score!

Answer Key

Quiz

- C — 13.** Eye opening to voice = 3, confused verbal response = 4, and obeys commands = 6. $3 + 4 + 6 = 13$.
- A — Report the change promptly.** The infographic identifies a **change of 2 or more points** as significant and states that it should be reported.
- B — 7.** No eye opening = 1, incomprehensible sounds = 2, and withdrawal from pain = 4. $1 + 2 + 4 = 7$.
- D — GCS 13: E3 V4 M6.** Each component should be documented separately rather than recording only the total score.
- B — 3.** Flexion of the arms/hands in response to pain represents **abnormal flexion (decorticate)** and receives a motor score of 3.

Glasgow Coma Scale — Clinical Unscramble

Answer Key

1. Opens the eyes without stimulation. SPONTANEOUS

Answer: SPONTANEOUS

2. Alert and oriented to person, place, time, and situation. ORIENTED

Answer: ORIENTED

3. Follows verbal commands appropriately. OBEYS COMMANDS

Answer: OBEYS COMMANDS

4. Purposefully moves toward a painful stimulus. LOCALIZES PAIN

Answer: LOCALIZES PAIN

5. Pulls away from a painful stimulus. WITHDRAWAL

Answer: WITHDRAWAL

6. Abnormal flexion of the arms and hands in response to pain. DECORTICATE

Answer: DECORTICATE

7. Abnormal extension of the arms in response to pain. DECEREBRATE

Answer: DECEREBRATE

8. This neurologic assessment evaluates eye, verbal, and motor responses. GLASGOW COMA SCALE

Answer: GLASGOW COMA SCALE

WORD BANK

DECORTICATE • DECEREBRATE • WITHDRAWAL • OBEYS COMMANDS • SPONTANEOUS • ORIENTED • LOCALIZES PAIN • GLASGOW COMA SCALE

Word Search

L	O	D	R	D	T	Y	R	O	W	I	B	O	N	I	I	L	O	R	E		
T	A	E	Y	X	Q	S	F	A	I	M	N	R	N	I	L	T	N	N	E	A	C
S	P	O	N	T	A	N	E	O	U	S	N	I	N	A	A	E	C	I	C	W	D
D	E	A	A	G	I	E	T	C	R	X	E	I	S	P	R	I	O	E	E	I	S
E	E	O	R	S	L	X	A	V	E	N	R	G	E	S	G	S	M	X	R	O	O
T	T	C	E	A	N	E	A	I	Q	A	O	S	M	E	C	M	F	C	E	T	N
N	R	E	O	H	E	I	R	E	E	R	A	T	T	Z	L	I	R	A	B	I	L
E	A	S	A	P	S	S	E	B	C	L	T	E	C	I	T	T	E	G	R	G	T
I	O	N	I	N	T	Q	N	O	A	G	O	Y	I	L	R	E	H	I	A	S	B
R	R	O	T	Y	E	I	H	O	J	A	R	G	C	A	E	O	E	E	T	S	R
O	L	P	E	L	A	S	C	E	M	G	D	I	C	E	I	N	O	F	E	E	
I	Z	S	R	O	S	E	I	A	M	S	T	T	O	R	T	S	A	A	S	A	
I	S	E	M	C	S	Y	E	T	S	E	H	T	T	E	E	I	E	O	S	N	
A	I	R	A	P	N	E	W	T	S	O	V	R	Z	E	A	E	B	N	E	A	D
N	A	L	S	E	E	O	X	N	R	B	X	T	R	E	R	C	L	S	I	E	L
E	C	A	J	N	R	P	N	I	A	O	I	R	K	O	A	S	S	P	S	R	D
A	I	B	E	O	E	E	A	I	N	F	U	L	S	T	I	M	U	L	U	S	
O	P	R	P	I	M	N	H	E	O	Z	D	I	T	E	A	O	F	I	F	T	C
C	C	E	A	R	T	I	S	W	A	R	D	H	T	I	W	N	M	D	L	B	O
E	J	V	A	E	L	N	N	I	I	C	N	E	U	R	O	L	O	G	I	C	M
T	O	X	R	I	L	C	T	T	A	D	S	T	D	I	L	T	M	T	T	W	
N	S	D	N	A	M	M	O	C	S	Y	E	B	O	M	R	E	N	A	S	I	H