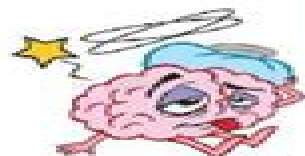


ASSESS LEVEL OF CONSCIOUSNESS



- ◆ **Full consciousness:** Awake and Alert
- ◆ **Lethargic:** sleeps frequently but awakens easily.
- ◆ **Obtunded:** extreme drowsiness, requires vigorous stimulation to awaken.
- ◆ **Stupor:** minimal movement, responds inappropriately, is awake briefly with vigorous stimulation or painful stimuli.
- ◆ **Comatose:** does not respond to verbal and tactile stimuli. May respond appropriately to painful stimuli.

ASSESS ORIENTATION

- ◆ **Oriented x3:** understands spoken and written language and responds appropriately.
- ◆ **Oriented x2:** Mild confusion, guesses date, may be able to recognize time of year. May not be able to follow instructions. May have memory deficits.
- ◆ **Oriented x1:** confused, unable to give date or time, unable to verbalize where or who they are. Has memory deficits and can be restless or agitated.
- ◆ **Disoriented:** patient does not answer appropriately or at all. May be hallucinating or agitated. Unable to follow directions.

PEERLA

- ◆ Test pupil response, size, symmetry, shape. They should be equal and reactive to light.
- ◆ Shine the penlight into each pupil. Constriction should be brisk and equal.
- ◆ Bilateral dilation can be caused by cerebral anoxia or anticholinergic medications. Be sure to assess the client's medication list and other symptoms.
- ◆ Bilateral constriction can be caused by: intracranial hemorrhage, opiates, or organophosphates.



CRANIAL NERVES

- ◆ **I: olfactory:** Smell, have the client identify familiar smells.
- ◆ **II: Optic:** Visual acuity, use snellen eye chart, assess peripheral vision.
- ◆ **III: Oculomotor:** Pupillary reaction, assess PERLA
- ◆ **IV: Trochlear:** Eye movement, patient follows finger without movement.
- ◆ **V: Trigeminal:** Facial sensation, touch patient's face, have them open their mouth.
- ◆ **VI: Abduens:** Motor function, patient follows finger without moving head.
- ◆ **VII: Facial:** Taste and face movement, have patient smile and puff cheeks, have patient differentiate between sweet and salty tastes.
- ◆ **VIII: Acoustic:** Hearing and balance, snap fingers close to patient's ear, have patient stand with feet together, arms at side and eyes closed for 5 seconds.
- ◆ **IX: Glossopharyngeal:** Swallowing and voice, have the patient swallow and say "ah"
- ◆ **X: Vagus:** Gag reflex, use a tongue depressor to swab and elicit a gag reflex.
- ◆ **XI: Spinal accessory:** Neck motion, have patient shrug and turn their head against resistance.
- ◆ **XII: Hypoglossal:** Tongue movement, have patient stick their tongue out and move it around.

- ◆ **Brain trick to remember the order of cranial nerves.**
"OOO to touch and feel a great velvet super hero"

ASSESS MUSCLE STRENGTH & FUNCTION

- ◆ Have the patient move all extremities.
- ◆ Have the patient squeeze your fingers.
- ◆ Hold your hands up for the patient to push and pull your hands.
- ◆ Have the patient hold their arms to their eyes. Note any drifts.
- ◆ Have the patient dorsiflex and plantar flex.
- ◆ Have the patient raise their legs without resistance.

Muscle strength scale

- 0: No muscle movement.
- 1: Visible muscle movement, no joint movement.
- 2: Movement at the joint but not against gravity.
- 3: Movement against gravity but not resistance.
- 4: Movement against resistance but less than normal
- 5: Normal strength.

GLASGOW COMA SCALE

- ◆ **Eye response**

Spontaneously	4
On command	3
To pain	2
No response	1
Score	_____
- ◆ **Verbal response**

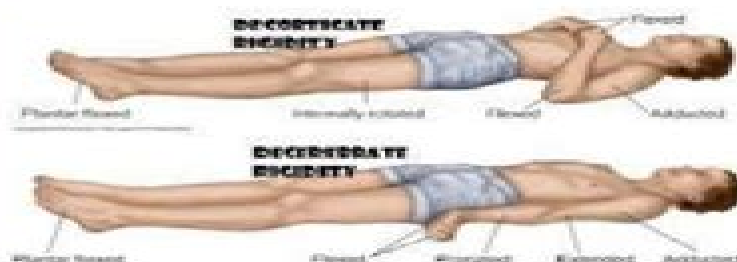
Alert and oriented	4
Confused	3
Inappropriate	2
Incomprehensible	1
score	_____
- ◆ **Motor response**

Follows direction	6
Localizes pain	5
Withdrawal from pain	4
Abnormal flexion	3
Abnormal extension	2
No response	1
score	_____



POSTURING

- ◆ **Decorticate:** An abnormal posturing in which a person is stiff with bent arms, clenched fists, and legs held out straight.
- ◆ **Decerebrate:** An abnormal body posture that involves the arms and legs being held straight out, the toes being pointed downward, and the head and neck being arched backwards.



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