6.4: Assessing Mental Status

Routine assessment of a patient's mental status by registered nurses includes evaluating their level of consciousness, as well as their overall appearance, general behavior, affect and mood, general speech, and cognitive performance. \[^{[1],[2]}\]

See the “General Survey Assessment” chapter for more information about an overall mental status assessment.

Level of Consciousness

**Level of consciousness** refers to a patient’s level of arousal and alertness. \[^{[3]}\]

Assessing a patient's orientation to time, place, and person is a quick indicator of cognitive functioning. Level of consciousness is typically evaluated on admission to a facility to establish a patient’s baseline status and then frequently monitored every shift for changes in condition. \[^{[4]}\]

To assess a patient's orientation status, ask, “Can you tell me your name? Where are you? What day is it?” If the patient is unable to recall a specific date, it may be helpful to ask them the day of the week, the month, or the season to establish a baseline of their awareness level.

A normal level of orientation is typically documented as, “Patient is alert and oriented to person, place, and time,” or by the shortened phrase, “Alert and oriented x 3.” \[^{[5]}\]

If a patient is confused, an example of documentation is, “Patient is alert and oriented to self, but disoriented to time and place.”

There are many screening tools that can be used to further objectively assess a patient's mental status and cognitive impairment. Common screening tools used frequently by registered nurses to assess mental status include the Glasgow Coma Scale, the National Institutes of Health Stroke Scale (NIHSS), and the Mini-Mental State Exam (MMSE).
**Glasgow Coma Scale**

The Glasgow Coma Scale (GCS) is a standardized tool used to objectively assess and continually monitor a patient’s level of consciousness when damage has occurred, such as after a head injury or a cerebrovascular accident (stroke). See Figure \(\PageIndex{1}\) for an image of the Glasgow Coma Scale. Three primary areas assessed in the GCS include eye opening, verbal response, and motor response. Scores are added from these three categories to assign a patient’s level of responsiveness. Scores ranging from 15 or higher are classified as the best response, less than 8 is classified as **comatose**, and 3 or less is classified as unresponsive.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Opening Response</td>
<td>4. Spontaneously&lt;br&gt;3. To speech&lt;br&gt;2. To pain&lt;br&gt;1. No response</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>5. Oriented to time, person and place&lt;br&gt;4. Confused&lt;br&gt;3. Inappropriate words&lt;br&gt;2. Incomprehensible sounds&lt;br&gt;1. No response</td>
</tr>
</tbody>
</table>

Figure \(\PageIndex{1}\): Glasgow Coma Scale

**National Institutes of Health Stroke Scale**

The National Institutes of Health Stroke Scale (NIHSS) is a standardized tool that is commonly used to assess patients suspected of experiencing an acute cerebrovascular accident (i.e., stroke). The three most predictive findings that occur during an acute stroke are facial drooping, arm drift/weakness, and abnormal speech. Use the following hyperlink to view the stroke scale.

A commonly used mnemonic regarding assessment of individuals suspected of experiencing a stroke is “BEFAST.” BEFAST stands for **B**alance, **E**yes, **F**ace, **A**rm, and **S**peech **T**est.

- **B**: Does the person have a sudden loss of balance?
- **E**: Has the person lost vision in one or both eyes?
- **F**: Does the person’s face look uneven?
- **A**: Is one arm weak or numb?
- **S**: Is the person’s speech slurred? Are they having trouble speaking or seem confused?
- **T**: Time to call for assistance immediately
Note

View the NIH Stroke Scale at the National Institutes of Health.

Mini-Mental Status Exam

The Mini-Mental Status Exam (MMSE) is commonly used to assess a patient’s cognitive status when there is a concern of cognitive impairment. The MMSE is sensitive and specific in detecting delirium and dementia in patients at a general hospital and in residents of long-term care facilities. Delirium is acute, reversible confusion that can be caused by several medical conditions such as fever, infection, and lack of oxygenation. Dementia is chronic, irreversible confusion and memory loss that impacts functioning in everyday life.

Prior to administering the MMSE, ensure the patient is wearing their glasses and/or hearing aids, if needed. A patient can score up to 30 points by accurately responding and following directions given by the examiner. A score of 24-30 indicates no cognitive impairment, 18-23 indicates mild cognitive impairment, and a score less than 18 indicates severe cognitive impairment. See Figure for an image of one of the questions on the MMSE regarding interlocking pentagons.

Note

Visit the following website for more information about the Mini-Mental Status Exam.

Oxford Medical Education

Figure: MMSE Question on Interlocking Pentagons


6. "glasgow-coma-scale-gcs-600w-309293585.jpg" by joshya on Shutterstock. All rights reserved. Imaged used with purchased permission.


10. "InterlockingPentagons.svg" by Jfdwolff[2] is licensed under CC BY-SA 3.0