

Head Trauma – Level II

HEAD TRAUMA

Level II
(No Level I)

Skill Level: RN /LPN

Definition: Trauma to the head that may or may not result in any alteration of cerebral function.

<p>Subjective:</p> <ul style="list-style-type: none">• "I hit my head" or "an object hit me on the head."• Awake and answering questions appropriately.• No loss of consciousness or brief loss of consciousness only.	<p>Assessment:</p> <ul style="list-style-type: none">• Alteration in comfort r/t head trauma• Risk for Ineffective Cerebral Tissue Perfusion• Risk for Fall• Risk for Mental Confusion
<p>Objective:</p> <ul style="list-style-type: none">• Not a high risk head injury, e.g. motor vehicle accident, crush injury, fall from more than 8 feet, suspected skull fracture, multiple injuries.• No evidence of serious neck injury.• No ecchymosis behind the ears (signs of possible skull fracture).• Age less than 65, no anti-coagulation.• No disturbance in balance lasting more than two hours.• No new seizure episode associated with head trauma.• Patient opens eyes spontaneously, obeys simple commands, and converses normally.• Evidence of only Minor Head Trauma:<ul style="list-style-type: none">--Vital signs normal for patient.--Oriented as to time, place, and person.--No focal neurological deficits.--May be brief loss of consciousness, under five minutes.--Retrograde amnesia is common.--A period of confusion is common. No persistent confusion for more than 2 hours.• Vomiting may occur after minor head injury but should not persist.	<p>Plan:</p> <p><u>Emergency transport for any of the following:</u></p> <ul style="list-style-type: none">• An acute, high risk head injury.• Appearance or suspicion of serious neck injury. Do not move the patient.• Loss of consciousness for more than five minutes.• A period of normal mental status followed by a diminished level of consciousness.• Persistent confusion or altered mental status for more than two hours.• Any persistent, new abnormal focal neurological finding(s). <p><u>Consider urgent transport for CT scan and evaluation for any of the following.</u></p> <ul style="list-style-type: none">• Patient is anti-coagulated (Coumadin, Aspirin, other meds).• Age 65 or older.• Suspicion of skull fracture.• Persistent balance problem for more than two hours.• New seizure associated with head trauma.• Diminished mental status during observation (see below). <p><u>Discuss with medical provider if possible.</u></p>

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	<p><u>Consider possible nursing admit to infirmary for observation and neurological checks.</u> <u>(See Addendum for Evaluation Tool.)</u></p> <ul style="list-style-type: none">• If apparent minor head trauma with symptoms of nausea, vomiting, or headache that persist more than two hours.• If patient is confused, may observe for up to two hours.• If infirmary not available, contact medical provider. <p><u>If minor head trauma and minor or no persistent symptoms, do baseline evaluation and repeat in 12 hours and again in 24 hours. (See Addendum for evaluation tool.)</u></p> <p><u>At nursing discretion may use any of the below:</u></p> <ul style="list-style-type: none">• Ibuprofen or Tylenol from unit.• <u>Naprosyn, Aspirin, and Ibuprofen are not recommended for pain management for pregnant patients, please instruct all pregnant patients to use Acetaminophen (available in housing units) for minor pain management.</u>• Tell patient not to take Aspirin.• Do not give opiates.• Consider a period of bedrest off work and sports.• Ice to injury prn.• Provider visit next available time.• Patient can return to general population.
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Nursing Education:

1. Moderate or severe head trauma is almost always associated with a high risk head injury, usually a motor vehicle accident, repeated direct trauma, or a fall from a height. At risk patients are those who are 65 or over and/or anti-coagulated. These patients often have persistent neurological impairment, including persistent confusion, focal neurological findings, and symptoms of nausea, vomiting, dizziness, and significant headache.
2. A variant of moderate head trauma is when patients “talk and deteriorate”. These patients usually present with minor neurological impairment, and their status worsens over the course of the first 48 hours after injury. Many of them have subdural or epidural hematomas or brain injury with edema. All patients with moderate or severe head trauma need neural imaging (non-contrast CT scan), and a period of close observation.
3. Minor Traumatic Brain Injury (TBI) is a temporary and brief interruption of neurologic function after head trauma, which may involve a brief loss of consciousness.
4. From a practical standpoint, minor TBI is a clinical diagnosis that requires a credible mechanism of injury. The most common persistent symptoms are nausea, vomiting, and headache. Patients can suffer brief transient neurological symptoms such as impaired awareness, and amnesia. Other subtle findings such as balance problems, impaired verbal memory, delayed comprehension, and slowed speech can occur.

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5. Research suggests that the longer the duration of loss of consciousness, the higher the possibility for an intracranial lesion.
6. Low risk patients are fully awake, not intoxicated, have no focal neurologic findings, and no evidence of skull fracture. These patients can be kept under competent observation for 12-24 hours and no neural imaging is needed.

Patient Teaching:

Patient may use anti-inflammatory medications or Tylenol for pain as needed. Other medication is by practitioner order only.

APPROVED:

Medical Services Manager

Date

Chief Medical Officer

Steve Shelton M.D.

Date

2/24/2015

Medical Director

Date

Effective Date: 3/2015
Revised: February 2015

**Oregon Department of Corrections
Health Service Section
Minor Head Trauma Assessment**

Instructions: Complete the appropriate response in each column, or enter code (see legend bottom of form), complete initial assessment then at 2, 4, 8, 12 and 24 hours post injury, discuss deterioration with practitioner or consider transport to ED. GCS less than 13 transport to ED

Date	Time	LOC	Glasgow Coma Scale				Movement / Strength			Cognition			Word recall 0 / 5 min	# of digits backwards	Global	Signature
			Eyes open	Verbal	Motor	Score	Gait/ Balance	Facial	Upper Ext	Lower Ext	Month	Date				
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Date	Time	Observations and Comments	Signature

LOC	Eye Opening	Verbal Response	Motor Response	Movement/Strength	Gait	Words	Digits	Gobal
A - Alert	4 - Spontaneous	5 - Oriented	6 - Obeys Commands	= - equal	N - Normal gait	Cat	5,2,8	Sz - Seizure
D - Drowsy	3 - To Speech	4 - Confused	5 - Localizes (pain)	R>L - Rt greater than Lt	ST - Stumbles	Pen	6,2,9,4	N/V - Nausea/Vomiting
S - Stuporous	2 - To Pain	3 - Inappropriate	4 - Withdraws (pain)	L>R - Lt greater than Rt	AT - Ataxia	Shoe	8,3,2,7,9	BV - Blurred Vision
C - Comatose	1 - None C closed by edema	2 - Incomprehensible 1 - none	3 - Flexion (pain) 2 - Extension (pain) 1 - None		Balance Can stand 15 sec feel together, eyes closed Y/N	Book Car	7,3,9,1,4,2	HA - Headache Dz - Dizziness Statement of overall Wellness

Patient Label