Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE

CATEGORY:	**SUBJECT:**	**SECTION:**
Nursing	**Head Injury Routine**	**H**
		POLICY:
		1
DATE:	**Administrator:**	
June 2015		
REVISION DATE:	**Director of Care:**	
September 2022		

HEAD INJURY ROUTINE

POLICY:

To recognize promptly changes indicative of rising intracranial pressure or shock.

DEFINITION OF HEAD INJURY:

Any sudden impact of blow to the head, with or without loss of consciousness, is considered a head injury.

PROCEDURE: The Registered Staff shall complete the Head Injury Routine on any witnessed fall affecting the head and unwitnessed fall affecting any cognitively impaired resident.

RN to do the following:

1. Determine vital signs of resident – temperature, pulse, respiration, and blood pressure. NOTE: If calling the ambulance, do not remove the resident from location except to avoid further hazard.
2. Determine level of consciousness and pupil size and reaction.
3. Notify physician for further instructions, or send resident to hospital for assessment, if condition warrants. Notify physician of transfer. Hold all sedation until consultation with physician.
4. If resident is placed on head injury routine, observe and chart the following. Frequency of observation to be as follows unless determined by physician: **q2hr x 4 hrs; q8hr x 24 hrs; q12hr x 24 hrs; q12hr x 48 hrs.**
   - Temperature, pulse, respiration, blood pressure. If temperature normal, take q8hr x 24 hrs.
   - Pupil size, measure in mm.
   - Pupil response, e.g., reacts briskly or slowly, does not react to light. If glaucoma or cataracts, do not assess, but note in documentation. **NOTE:** Pupil reaction may be inaccurate due to glaucoma or cataracts.
   - Limb movement (upper and lower limbs), e.g., equal, strong, weak, paralysis.

- Level of consciousness, e.g., alert, easily aroused, drowsy, increased confusion, responds to directions. **NOTE: Monitoring for 48 hours allows for assessment in case of a slow bleed.**

5. Notify the physician if there is a sudden change in vital signs and neurological assessment, or if the resident:
   - becomes increasingly restless, irritable, or confused.
   - becomes nauseated or vomits.
   - displays abnormal shaking movements or has a seizure.
   - complains of dizziness and/or visual disturbances.
   - has gradually increasing BP, either systolic or diastolic.
   - complains of a severe headache lasting more than four hours after head injury.
   - has progressive weakness or paralysis of extremities.
   - has a temperature above 37.8º C.
   - develops a stiff neck or cannot be easily roused.

6. Document observations on Head Injury Routine Record (H.I.R. R.) form and progress notes. Accurate sequential documentation is critical for medical assessment.

NOTE: If a slow bleed, changes may occur even after 48 hours, therefore ongoing assessment is important.

NOTE: In discussion with Dr. Holloway, he has approved Tylenol as long it does not have codeine in it.

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Head Injury Routine Record

(H.I.R.R.)

Resident Name: _____ Location: _____
_____

Date / Time	Temperature	Pulse	Respiration	Blood Pressure	Pupil Size		Pupil Responses		Motor Response				Conscious Level	Remarks/Signature
									Upper Limbs		Lower Limbs			
					Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt		

Pupil Size (mm) 1 2 3 4 5 6 7 8

Pupil Response	R	Racing
	RB	Reacting Briskly
	RS	Reacting Slowly
	F	Fixed

Motor Response	S	Strong
	M	Moderate
	W	Weak
	A	Absent

Conscious Level	1	Alert	6	Responds Verbally
	2	Oriented	7	Moves to Command
	3	Confused	8	Decerebrate Response
	4	Restless	9	No Response
	5	Drowsy	10	

HEAD INJURY ROUTINE RECORD INSTRUCTIONS

PURPOSE:

To ensure accurate recording of a resident's condition.

PROCEDURE:

1. Obtain the Head Injury Routine Record form (H.I.R.R.).
2. Complete the identification section. All entries must be made in ink.
1. Enter date, time, and frequency of observation, to be determined by the physician – Frequency of observation to be as follows unless determined by physician: **q2hr x 4 hrs; q8hr x 24 hrs; q12hr x 24 hrs; q12hr x 48 hrs.**
3. Record pulse, respiration, blood pressure.
4. **Pupil size:** refer to comparative size at the bottom of the form and enter corresponding number.
5. **Pupil Response**: use code.
6. **Motor Response**: use code.
7. **Consciousness Level**: use code.
8. Enter any other remarks and sign with full signature and date.
9. File in nurses' notes follow through with charting.