

CENTRAL STATE HOSPITAL  
POLICY AND PROCEDURE

SUBJECT: **CARE OF THE CLIENT WITH HEAD TRAUMA (NEW)**

ANNUAL REVIEW MONTH: March

RESPONSIBLE FOR REVIEW: CSH Chief Nurse Executive

LAST REVISION DATE: March 2008

---

**PURPOSE:**

To provide for nursing process that will identify the symptoms indicative of serious complications of head trauma in order to provide early intervention and treatment.

**EQUIPMENT:**

Flashlight  
Blood Pressure Cuff  
Stethoscope  
Watch with second hand

---

**PROCEDURE:**

**First Aid:**

1. Maintain proper body alignment, maintaining the safety of the person's neck, if indicated.
2. Maintain an open airway.
3. Ensure breathing and circulation (CPR if needed).

**Initial Evaluation:**

1. Check vital signs: Blood pressure, pulse and respirations.
2. Control bleeding with pressure.
3. Check the level of consciousness (alert, responsive, non-responsive, and/or combative).
4. Check for nausea and/or vomiting.
5. Check for ability to move extremities.
6. Check pupil size and reactivity to light.
7. Check for bleeding or drainage of clear (cerebrospinal fluid) from the eyes, ears, nose or mouth.

**Obtain History:**

Gather information regarding the nature and extent of the injury:

- a. What caused the injury?
- b. Did an object strike the head?
- c. Did the person fall?
- d. What was the force of the injury or blow to the head?
- e. Was there a loss of consciousness? If so, for how long?
- f. Is the person alert now?
- g. Is/was there any bleeding or discharge from the person's eyes, ears, nose or mouth?

**Notify the Physician:**

Call the responsible Medical Staff Member and report the head injury and the information obtained above if there are positive findings on the evaluation.

**Document:**

1. Document the above evaluation in the person's medical record.
2. Document the notification of the responsible Medical Staff Member in the person's medical record.
3. Document any orders given by the Medical Staff Member.

**Ongoing Evaluation:**

If the responsible Medical Staff Person orders the "Head Trauma Protocol," or if indicated by the nursing evaluation, evaluate the person per the Protocol (CSH 59A), notifying the Medical Staff for changes as indicated on the Protocol. Unless otherwise ordered by the responsible Medical Staff Person, the Head Trauma Protocol requires evaluation every hour for 4 hours, then every 2 hours for 8 hours, and then every 4 hours for 24 hours.

**Document:**

Document all findings on the Head Trauma Protocol Checklist (CSH 59A).

**Approved:**

**This policy has been approved by the CEO and CMO in March, 2008.**

Attachment: Head Trauma Protocol Checklist (CSH 59A)

**HEAD TRAUMA PROTOCOL CHECKLIST**

Complete when “Head Trauma Protocol” is ordered or indicated by nursing assessment.

Unless otherwise ordered by the responsible Medical Staff Person, the Head Trauma Protocol requires evaluation:

- Every hour for 4 hours, then
- Every 2 hours for 8 hours, and then
- Every 4 hours for 24 hours.

Call the Physician for any changes from the person’s baseline as indicated below:

- 1) Decreasing level of alertness;
- 2) Decreasing orientation;
- 3) Does not open eyes;
- 4) One pupil becomes larger or smaller than the other;
- 5) Stops moving one or more extremities;
- 6) Changes in vital signs of slowing or irregular heart rate, trouble breathing, increasing or decreasing blood pressure – all compared to that person’s normal vital signs;
- 7) Unrelenting or severe headache not relieved by simple analgesics such as Tylenol;
- 8) Starts vomiting;
- 9) Has one or more seizures.
- 10) Has bloody or clear (CSF) discharge from eyes, ears, nose or mouth.

DATE AND TIME OF EVALUATION: Every 1 hour x 4 hours	Baseline	1 hour	2 hours	3 hours	4 hours
Describe the level of alertness (arouse the person if necessary)					
Converses and is oriented?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Opens eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pupils:	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>
Moves extremities?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bloody or Clear discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vital Signs	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:
Headache?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Nurse Signature</i>					

**Stamp Plate**

DATE AND TIME OF EVALUATION: Every 2 hr x 8 hrs	2 hours	4 hours	6 hours	8 hours
Describe the level of alertness (arouse the person if necessary)				
Converses and is oriented?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Opens eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pupils:	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>
Moves extremities?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bloody or Clear discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vital Signs	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:
Headache?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Nurse Signature</i>				

DATE AND TIME OF EVALUATION: Every 4 hrs x 24 hrs	4 hours	8 hours	12 hours	16 hours	20 hours	24 hours
Describe the level of alertness (arouse the person if necessary)						
Converses and is oriented?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Opens eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pupils:	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>	Normal/Equal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/> Unequal <input type="checkbox"/>
Moves extremities?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bloody or Clear discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vital Signs	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:	Pulse: BP: R:
Headache?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Nurse Signature</i>						