

## HEAD INJURIES

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><b>Subjective:</b></p> <ul style="list-style-type: none"> <li>• "I hit my head" or "an object hit me on the head".</li> <li>• Awake and answering questions appropriately.</li> <li>• Brief loss of consciousness only.</li> </ul>	<p><b>Assessment:</b></p> <ul style="list-style-type: none"> <li>• Alteration in comfort r/t head trauma</li> <li>• Risk for Ineffective Cerebral Tissue Perfusion</li> <li>• Risk for Fall</li> <li>• Risk for Mental Confusion</li> </ul>
<p><b>Objective:</b></p> <ul style="list-style-type: none"> <li>• Vital signs should be within normal limits.</li> <li>• Oriented as to time, place, and person.</li> <li>• No focal neurological deficits.</li> <li>• A brief period of confusion is common.</li> <li>• No ongoing change in level of consciousness.</li> <li>• No evidence of serious neck injury.</li> <li>• Vomiting may occur after head injury.</li> <li>• May have symptoms of concussion (see below).</li> <li>• Patient opens eyes spontaneously, obeys simple commands, and converses normally.</li> </ul>	<p><b>Plan:</b></p> <p>At nursing discretion may use any of the below:</p> <ul style="list-style-type: none"> <li>• Ibuprofen or Tylenol from unit. <b>Tell patient not to take Aspirin.</b></li> <li>• <b>Do not give opiates.</b></li> <li>• Ice to injury/prn.</li> <li>• If the patient is able to respond appropriately to questions, and is neurologically intact, recheck in 12-24 hours.</li> <li>• If any signs of altered mental status, altered neurological findings or history of loss of consciousness, check CBG and contact practitioner immediately. At a minimum, place patient for observation every two hours for 24 hours in a hospital or infirmary setting.</li> <li>• If this is an acute, traumatic injury and there is appearance or any suspicion of significant neck injury, do not move the patient. Contact emergency transport. Keep patient NPO.</li> </ul>

**Nursing Education:**

1. Vomiting one time frequently occurs. This is not necessarily a sign of severe head injury.

## Head Injuries – Level II

2. The two most common concussion symptoms are confusion and amnesia. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.
3. Other immediate signs and symptoms of a concussion may include:
  - Headache
  - Dizziness
  - Ringing in the ears
  - Nausea or vomiting
  - Slurred speech
4. Some symptoms of concussions don't appear until hours or days later. They include:
  - Mood and cognitive disturbances
  - Sensitivity to light and noise
  - Sleep disturbances

### **Patient Teaching:**

1. Be alert to projectile vomiting, pupil change, neck stiffness, decreased mental acuity, depressed sensorium, altered personality, or any unusual behavioral or coordination changes.
2. Patient may use Ibuprofen or Tylenol for pain prn.
3. Other medication by practitioner order only.


### **APPROVED:**

\_\_\_\_\_  
Medical Services Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief Medical Officer

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Medical Director

7/28/09  
\_\_\_\_\_  
Date

Effective Date: July 2009  
Revised: June 2009