

## Head Injury - After Fall as Inpatient - Full Clinical Guideline

Reference No: CG-T/2013/112

### **Aim**

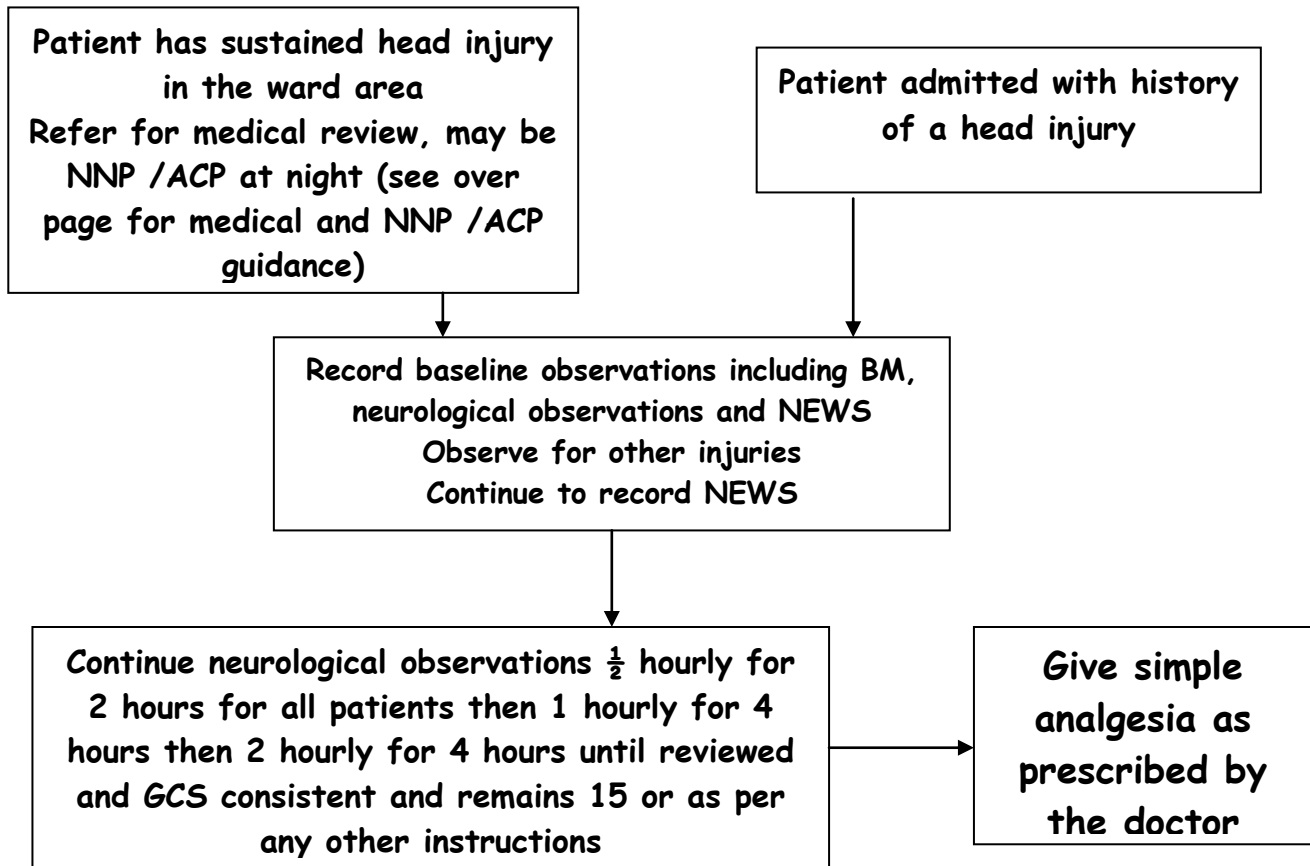
To aid the management of head injury patients, in terms of accurate timely recordings of neurological observations and to ensure prompt interventions and actions occur where necessary.

### **Scope**

All staff involved in the care of adult in-patients with head injuries and the recording of neurological observations.

### **References**

NICE Clinical Guideline No. 176 June 2014 (updated June 2017). Head Injury. Triage, assessment, investigation and early management of head injury in infants, children and adults.

**HEAD INJURY - AFTER FALL AS INPATIENT - NURSING GUIDANCE**

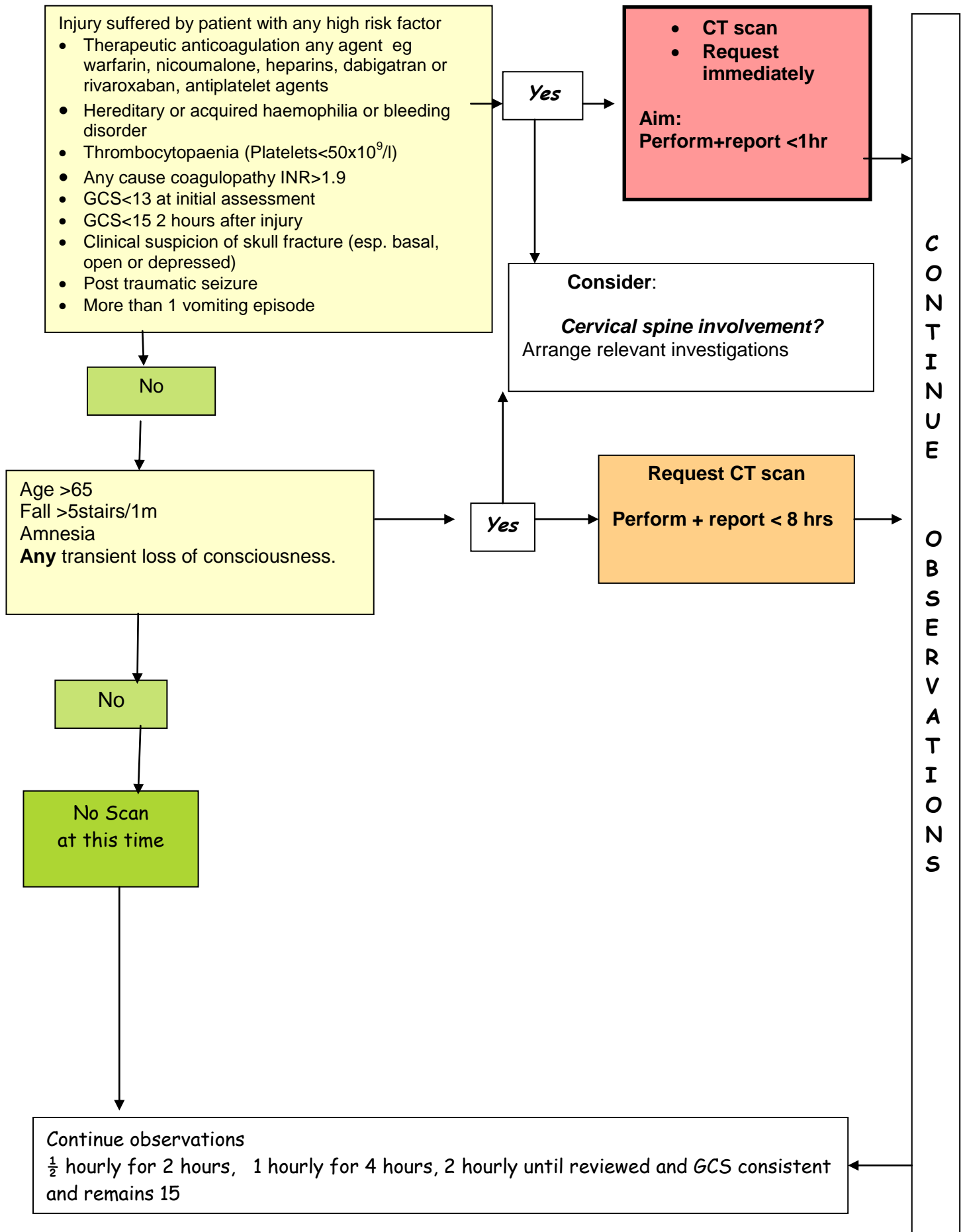
**If the patient's condition deteriorates at any stage report to NNP/ ACP / medical staff to obtain urgent review and restart ½ hourly**

**Changes requiring immediate review by medical staff**

- Agitation, increased confusion or abnormal behaviour
- Severe or increasing headache or persistent vomiting
- New or evolving neurological symptoms or signs, such as pupil inequality or asymmetry of limb or facial movement
- Changes in other vital signs recordings

Complete IR1 form at the earliest opportunity by the person who witnessed the fall or was involved in the immediate post fall period in the case of an unwitnessed fall; and record the time and details in the patient's healthcare record

**HEAD INJURY - AFTER FALL AS INPATIENT - MEDICAL AND NNP / ACP GUIDANCE**



**Guidance regarding cessation of observation, delayed deterioration risk and re-imaging**

There is a reasonable balance needing to be struck between the serious recognised risks of sleep deprivation (delirium, *increased* falls risk etc) from persistent close observation and the risks of deterioration from delayed or progressing intracranial bleeding. There is little firm guidance or evidence available.

To give some context, from the literature:

In the patients scanned within 1 hour of injury with confirmed intra-cranial bleeding (ICH), progression of bleeding is thought to occur in:

Less than 4% pts >24hrs post injury  
Less than 1% pts >48hrs post injury

Delayed acute subdural haemorrhage (DASH) presenting clinically >24hrs, after *normal initial CT*, estimated <0.5% of all mild head injuries where lowest GCS >12. Failure to achieve pre-trauma GCS by 24hours should trigger re-discussion of imaging.

The only consistently identified risk factor for delayed presentation or bleed is demonstrable coagulopathy (INR>2.4), although other forms of coagulopathy should raise index of suspicion.

Delayed presentation, whilst rare, is often clinically insidious and a low threshold to discuss imaging should be maintained in the high risk groups.

**Documentation Controls**

Development of Guideline:	Head Injury Working Group
Consultation with:	Emergency Department Consultant, Chair of Trust Falls group
Approved By:	Falls Group - 15/2/18 Integrated Care Division - 21/2/18 Surgical Division - 6/3/18 Medical Division - 22/2/18
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