**Head Injury Pathway for Nursing Homes**

‘Head injury’ for the purposes of the guideline is defined as any trauma to the head, other than superficial injuries to the face.


Throughout this pathway the wishes of the resident and their relatives must be taken into consideration.

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**Resident falls and suffers a bang to the head**

**Resident conscious**

**Resident unconscious**

**OBSERVATIONS**

Undertake and record the following every 15 minutes:

- GCS (SEE BELOW)
- Heart rate
- Respiratory rate
- Blood Pressure
- Pupil size and reactivity
- Limb movements
- Temperature

**Do any of the following criteria apply?**

- GCS less than 15 on initial assessment (or deterioration in GCS if normally < 15)
- Any suspicion of a skull fracture (Box 2, page 2)
- Penetrating injury to head
- Seizure since the injury
- Any new focal neurological deficit since the injury (Box 1, page 2)
- More than one episode of vomiting since the injury
- Current treatment with warfarin
- History of bleeding or clotting disorders
- Any amnesia since the injury
- Any loss of consciousness as a result of the injury
- Worsening headache not relieved by simple analgesia
- Any previous cranial neurological interventions

**Yes** – the qualified nurse on duty to undertake assessment below and carry out any immediate first aid required

**Yes - Call 999 and accompany to hospital with details**

**NO**

Inform the Practice of the incident ensuring it is recorded on the patient’s notes

**Request medical review by GP or delegated ANP the same day**

**Observe for any change in condition and act as above – NOTE changes could occur several weeks after the bang to the head**
Where applicable this guidance must be read in conjunction with the Mental Capacity Act (2005), and any needs assessments, care planning and decisions must be considered in relation to this legal framework. NICE Compliant 2007

**Glasgow Coma Scale (GCS)**

**The Glasgow Coma Scale for adults**
The Glasgow Coma Scale is scored between 3 and 15, 3 being the worst, and 15 the best. It comprises three parameters: best eye response, best verbal response, best motor response. The definition of these parameters is given below.

**Best eye response (4)**
1. No eye opening
2. Eye opening to pain
3. Eye opening to verbal command
4. Eyes open spontaneously

**Best verbal response (5)**
1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Orientated

**Best motor response (6)**
1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localising pain
6. Obeys commands
Sample Observation Proforma

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**The Newcastle upon Tyne Hospitals NHS Foundation Trust**

**NEUROLOGICAL OBSERVATION CHART**

<table>
<thead>
<tr>
<th>Surname</th>
<th>Patient Id No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename</td>
<td>D.O.B.</td>
</tr>
<tr>
<td>Address</td>
<td>NHS No.</td>
</tr>
<tr>
<td>Sex</td>
<td>Male / Female</td>
</tr>
</tbody>
</table>

**Coma Scale**

- Eyes open
- Spontaneously
- To speech
- To pain
- None

- Best verbal response
- Comatose
- Confused
- Inappropriate words
- Incomprehensible
- None

- Best motor response
- Obey commands
- Localise pain
- No pain awareness

**G.C.S. Total**

**DATE**

**TIME**

**Diagnosis**

**Pupils**

<table>
<thead>
<tr>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>Reaction</td>
</tr>
<tr>
<td>Size</td>
<td>Reaction</td>
</tr>
</tbody>
</table>

**Limbs**

- Normal power
- Mild weakness
- Severe weakness
- Spasticity
- Extension

- No response
- Normal power
- Mild weakness
- Severe weakness
- Extension

Reference:

http://www.nice.org.uk/nicemedia/live/11836/36266/36266.doc#adult