Elizabeth Finn Homes

Head Injury Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Assessing needs

We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

Delivering evidence-based care and treatment

We plan and deliver people’s care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Monitoring and improving outcomes

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Scope

This policy is aimed at all staff working in EFH that come across a resident that has sustained a head injury. The very nature of residents requiring a care home puts them at risk of trips and increased risk of head injuries. EFH will have in

place a policy to assess the resident's head injury requirements for emergency support but aiming to avoid unnecessary hospital admission and keeping the resident safe.

This policy and procedure are provided for the regulated activity of accommodation for people with personal care and nursing.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

EFH will ensure all staff in the home have knowledge, training and competency to minimise incidents and injuries from falls, but when they do happen are competent to undertake an assessment of injuries, including head injury, and raise emergency response from the ambulance service via 999.

This policy must be read and followed by all staff working within the organisation who work with residents and may interact with them during their shift.

EFH will ensure all care staff are trained and assessed as competent in basic life support and first aid on a regular basis. This will be documented in their training records.

When encountering a resident who has sustained a suspected head injury, basic first aid and assessments should be undertaken in the first instance including:

- Being safe to approach. e.g. no electrical hazards or slippage hazards are present.
- Be aware of the AVPU tool to assess the resident:
- A - Are they alert and can they open their eyes?
- V - Can they respond to as you would expect them to if you talk to them, can they answer simple questions?
- P - Does the resident respond to pain, if you give a pinch to the ear lobe, do they move or open their eyes?
- U - Are they responsive? If Unresponsive then call 999.

If the resident is conscious, responding and moving around normally then they can be placed in a safe comfortable place for further assessment. Call either the GP or 111 for advice in any head injury even if considered minor.

Even if the resident appears 'normal' after the head injury, any discharge from the ear or nose that is blood or a water-like discharge should be treated as a potentially severe head injury and 999 called and this information relayed to control room and responding paramedics.

When the staff look at the resident do their pupils look the same or is one larger than the other and not normal for the resident? This is a sign of a more serious head injury.

Is the resident's conscious level altering/deteriorating/increased confusion?

Did the resident blackout?

Do they have a severe headache that is not resolving?

Are they vomiting?

Do they have a significant open wound?

Any doubt at all then the staff must seek advice from either GP, 111 or 999.

If there is any doubt regarding the resident sustaining more severe injuries for example possible broken bones, is in a lot of pain or acting confused then either dial 111 for advice or 999. Do not attempt to move the resident in case it worsens their condition. Keep them warm and reassured, if their condition deteriorates whilst waiting for assistance then dial 999 explaining what is happening.

Be aware that side effects from head injuries can present, hours, days or even weeks after the event.

All actions should be documented in the residents' notes, family or next of kin informed of the event and subsequent actions.This should be documented on Access and Clinical Accident / Incident Form 3.0 and the Follow on form 3.01.

The Policy

EFH is committed to supporting residents to have as independent and normal life as possible, in spite of medical conditions which may make this difficult. EFH will provide staff with training, knowledge, competency assessments and regular updates in the management of head injuries. This policy should be read in conjunction with policies on First Aid and Basic Life Support.

This information is to be used in tandem with the Management of Slips, Trips and Falls Policy

This policy is commensurate with the NICE Clinical Guideline CG161 – Surveillance of falls in older people, assessing risk and prevention.

Definition

Neurological observations relate to the evaluation of the integrity of an individual's nervous system.

Indications

Neurological observations are required to monitor and evaluate changes in the nervous system by indicating trends thus aiding diagnosis and treatments which in turn may affect prognosis and rehabilitation. Changes in neurological status can be rapid and dramatic or subtle, developing over minutes, hours, days or weeks. Therefore the frequency of neurological observations will depend on a resident's condition. As per the unwitnessed residents' falls procedure, any unseen fall should be managed by adhering to the protocol outlined.

Neurological function is assessed by observing five critical areas:

1. Level of consciousness
2. Pupillary activity
3. Motor function
4. Sensory function
5. Vital signs

A brief explanation of these five criteria is discussed below.

Categories of consciousness include the following:

1. Full consciousness: The resident is aware of self and environment and this is reflected in the ability of the resident to be aroused and respond to external stimuli. Ensure any history of decline in the
2. resident's sensory and/or motor deficits is acknowledged.

3. Lethargy/drowsiness: The resident is inactive, indifferent, responds slowly and does not respond to verbal commands.

4. Coma: The resident has total absence of awareness of self and environment. Response to arousal from painful stimuli may be absent.

Arousability will depend on extent of brain injury and conscious levels discussed above.

Assessment of level of Consciousness

Assessment involves three phases:

1. Eye opening
2. Evaluation of verbal response
3. Evaluation of motor response

The level of consciousness must be assessed using the Glasgow Coma Scale criteria, designed to grade the severity of impaired consciousness in individuals with traumatic head injuries.

In the event of Head Injury / Fall the NEWS2 Form on Access and Clinical must be implemented without delay.

Evaluation of Pupillary Activity

Careful examination of the reaction of the pupils to light is an important part of neurological assessment. The size, shape, equality, reaction to light, and the position of the eyes should be noted and charted on the neurological observation chart.

Evaluation of Motor Function

Damage to any part of the nervous system can affect the ability to move. Motor function assessment involves and evaluation of the following:

1. Muscle strength
2. Muscle tone
3. Muscle co-ordination
4. Reflexes
5. Abnormal movements

Muscle strength: This involves testing the residents muscle strength against ones own muscle resistance and then against the pull of gravity.

Muscle Tone: This involves flexing and extending the residents limbs on both sides and noting how well such movements are resisted. Increased resistance would denote increased muscle tone and vice versa.

Muscle coordination: Any injury that involves the brain will affect co-ordination. Assessment of hand and leg co-ordination can be achieved by testing the rapidity and rhythm of alternating movements.

Reflexes

Amongst the most important reflexes are blinking, gag and swallow, plantar. Tested and noted on neurological observation chart.

Abnormal Movements

When carrying out neurological observations, any abnormal movements such as seizures, tics and tremors must be noted.

Vital Signs

It is recommended by the NICE guidelines that assessment of vital signs should be made in the following order:

1. Respiration
2. Temperature
3. Blood pressure
4. Pulse

Respiration: Of the four vital signs, respiratory patterns give the clearest indications of how the brain is functioning since respirations are controlled by different areas of the brain. The rate, character and pattern of a resident's respiration must be noted and charted.

Temperature: Damage to certain areas of the brain may result in grossly fluctuating temperature recordings

Blood Pressure, pulse and respirations: Observations of blood pressure, respirations and pulse will provide evidence of increased intracranial pressure.

It must be noted that abnormalities of blood pressure and pulse usually occur late, after the resident's level of consciousness has begun to deteriorate. It is essential that the individual carrying out and recording neurological observations examines the resident closely, noting consciousness levels as above.

General Points

- Staff should be aware of the resident's history and care plan.
- Staff should be looking for changes in mood, intellect, memory and personality.
- Staff should refer to and utilise the unwitnessed fall procedure to note the frequency of observations and guidelines when calling the emergency services.

Anti-coagulants & Head Injury

Where a resident has been prescribed an anticoagulant medication and sustains a head injury then the emergency services must be called immediately. (999). NICE guidelines advise that they will be at greater risk of an intracranial bleed and prompt action is vital to allow appropriate management.

Training

Care staff are provided with training regarding Emergency First Aid / Management of a Head Injury at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of Emergency Procedures of a resident where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

Review date	Next Review Date
May 2024	May 2027