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**Care of Brain Injury Policy**

**[Date of Issue]**

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# Introduction

A traumatic brain injury is a structural injury and/or a physiological disruption of brain function resulting from an external traumatic force injury. The extent of injury can range from mild to severe and is accompanied by any number of symptoms that can also significantly vary in severity and prognosis.

# Policy Statement

[Company Name] is committed to providing person-centred and appropriate care in line with specialist care plans, if available.

# Scope

This policy and the procedures apply to all healthcare professionals and care workers involved in direct client or client care.

The Registered Manager is responsible for supporting staff in the care of clients with traumatic brain injury and for ensuring that the contents of the policy remain appropriate and in line with the standards for current best practice.

# Definitions

**Vegetative state:** diagnosis is made a minimum of one month after injury in the presence of all of the following:

* no evidence of awareness of self or environment, and an inability to interact with others
* no evidence of sustained, reproducible, purposeful or voluntary behavioural responses to visual, auditory, tactile or noxious stimuli
* no evidence of language comprehension or expression
* intermittent wakefulness manifested by the presence of sleep-wake cycles
* sufficiently preserved hypothalamic and brain stem autonomic functions to permit survival with nursing and medical care
* bowel and bladder incontinence
* variably preserved cranial nerve reflexes and spinal nerve reflexes.

**Minimally conscious state:** clients have clear evidence of one or more of the following:

* follow simple commands
* demonstrate gestural or verbal yes/no responses (regardless of accuracy)
* verbalise intelligibly
* demonstrate purposeful behaviour, including movements or affective behaviours which are contingent upon environmental stimuli.

# Procedures

Clients who have been discharged from hospital with ongoing or long-term complications following a traumatic brain injury could display a variety of symptoms in varying degrees of severity, dependent on the extent and location of the injury.

All clients with traumatic brain injuries requiring ongoing care and/or rehabilitation, should be discharged from hospital with a multi-professional care plan in place. This care plan must be clearly documented and may include, as an example, physiotherapy, occupational therapy, speech and language therapy and neuropsychology. It is essential that care plans be adhered to as far as practicable and that they remain appropriate and be specific and person-centred through routine reviews. If a client’s condition changes in a manner that alters the appropriateness or practicability of the plan, attending healthcare professionals should confirm when the next review is due by the specialist area affected and contact the relevant specialist team. Intervention is needed sooner, for example, if a client’s ability to swallow deteriorated and they required an urgent assessment to assess the risk of aspiration.

Consent for any care, treatment and/or interventions should be obtained from the client before undertaking a task, and for clients who lack capacity, healthcare professionals should follow the guidelines provided by the Mental Capacity Act 2005.

# General Care and/or Support

The main effects of brain injury are grouped into three categories, as follows, and routine and specific care should be provided in line with the client care plan and the relevant policies listed under the ‘Associated Policies and Procedures’ section at the end of this policy:

* Physical:
	+ mobility – both movement and balance can be affected, and clients may require specific aids
	+ spasticity – client’s may have stiff or weak limbs that affect their range of movement and/or cause discomfort
	+ weakness – clients may have hemiparesis or hemiplegia, meaning they require assistance with activities of daily living
	+ ataxia – uncontrolled movement or tremors may affect a client’s ability to perform intricate tasks, such as shaving
	+ sensory impairment – client’s may be unable to feel when pressure areas are compromised, and eyesight may also be affected
	+ fatigue – allow the client to control pace and rest as needed
	+ speech – clients may experience a loss of speech or an inability to clearly express themselves, potentially requiring aids or rehabilitation activities. Encourage clients to speak slowly and clearly, ask simple questions, do not make assumptions on what you think is being said and ask for assistance from family and/or carers if there is difficulty understanding
	+ epilepsy – clients on anti-epileptic drugs may experience increased fatigue. The effectiveness of any medications should be routinely reviewed, and seizures should be managed accordingly
	+ hormonal imbalances – clients can experience depression, impotence, mood swings, fatigue, muscle weakness, reduced body hair, fluctuating body weight, sensitivity to cold, increased thirst and excessive urine production, among others, as well as the possibility of conditions such as hypopituitarism and neurogenic diabetes. Suggest referral to GP if symptoms are present but undiagnosed
	+ loss of sexual function
	+ continence – clients may require long-term catheterisation or bowel management procedures
	+ nutrition – clients may require long-term or alternative nutrition solutions, such as gastrostomy feeding.
* Cognitive:
	+ memory – particularly short-term memory and the ability to remember faces and names. Suggest clients write down essential information and only present new information in small amounts and try several different ways (i.e., visual and verbal)
	+ language loss (aphasia) – clients may have difficulty understanding what is said or read (receptive) or, alternatively, finding the right words to express themselves (expressive). Use simple sentences, present only one idea at a time and be client
	+ impaired visual-perception – clients may be unable to recognise faces, make sense of ordinary pictures and shapes or fail to respond to visual stimuli on one side of the visual field
	+ reduced initiation and motivation – should not be mistaken for laziness but depression should not be excluded. Structure activities or interventions to avoid long periods of inactivity
	+ reduced concentration – can affect ability to complete tasks and memory. Reduce distractions, keep tasks short and provide prompts when needed
	+ reduced information processing – difficult for clients to organise facts and can result in ‘information overload’. Break tasks down into manageable steps
	+ repetition – may be unable to move onto another topic, returning to the same topic and/or action again and again. Advise client that the topic is being changed and remind them if they return to the previous topic
	+ impaired reasoning – clients may be unable to think logically, understand rules or follow discussions
	+ impaired insight/empathy – provide clear and simple, but cautious, explanations of why the client is unable to perform a task and do not encourage tasks that a client will not be able to achieve
	+ reduced problem solving.
* Emotional and behavioural – calm, supportive behaviour is essential to managing clients with emotional and/or behavioural issues:
	+ personality changes
	+ mood swings
	+ depression
	+ anxiety
	+ frustration and anger
	+ disinhibition
	+ abusive/obscene language
	+ impulsiveness
	+ obsessive behaviour
	+ loss of confidence.

# Clients in a Minimally Conscious or Vegetative State

While most clients will likely be able to breathe for themselves, some clients may require mechanical airway assistance, such as a tracheostomy and/or invasive or non-invasive ventilation. These clients should receive airway and ventilatory management according to the specific policy (i.e., see Care of the Mechanically Ventilated Client Policy for mechanically ventilated clients).

Any potential changes in conscious level should be assessed using a recognised and validated assessment tool and if any changes are noted healthcare professionals should suggest an appropriate referral, either to the clients GP or to their specialist team, likely dependent on their stage and length of recovery.

# Family/Carers

For the majority of clients, a family member will likely act as the client’s primary carer. Therefore, it is important that the client’s family and/or carer are continually updated on any changes to the client’s condition, how this may affect their care and any changes to the care/treatment plan as a result of this. They should also be advised of any new or developing risks and what they should do if certain situations arise, for example if the client were to aspirate while eating or drinking. Client’s families and/or carers should be involved in any care provided by attending healthcare professionals, where possible and if desired, and they should also be provided with the opportunity to ask questions and be advised where additional support can be obtained, such as brain trauma charities.

# New Traumatic Brain Injury

[Delete Section if Appropriate]

Healthcare professionals/carers attending a client who they suspect may be suffering from a newly acquired traumatic brain injury should call the emergency services (999) if the client has sustained a head injury and has/had any of the following:

* Glasgow Coma Scale (GCS) score of less than 15 on initial assessment
* loss of consciousness
* focal neurological deficit
* suspicion of skull fracture or penetrating head injury
* amnesia of events before or after
* persistent headache
* vomiting
* seizures
* previous brain surgery
* high-energy head injury
* history of bleeding or clotting disorders
* current anticoagulant therapy
* current drug or alcohol intoxication
* safeguarding concerns
* continuing concern by the professional about the diagnosis.

If the above risk factors are absent but the client is demonstrating any of the following, consider referral to an emergency department, minor injuries or primary care depending on clinical judgement and severity:

* irritability or altered behaviour
* visible trauma to the head not covered by the above but still of concern
* no one is able to observe the injured person at home
* continuing concern by the injured person or their family or carer about the diagnosis.

For clients requiring emergency services, healthcare professionals should perform an ABCDE assessment and monitor/intervene as appropriate to the situation, expertise and equipment availability while awaiting ambulance arrival. Handover to the emergency services using either a SBAR (Situation, Background, Assessment, Recommendation) or RSVP (Reason, Story, Vital signs, Plan) format.

Clients newly discharged following a traumatic brain injury, particularly those who underwent neurosurgery, should be monitored for complications including a subdural haematoma or hydrocephalus.

# Monitoring

The effectiveness of this policy will be monitored through the routine audit of this and other care specific policies, along with client/carer feedback.

# Related Policies

* Care of the Non-Invasively Ventilated Client Policy
* Care of Tracheostomy Policy
* Enteral and Parenteral Feeding Policy
* Falls Management Policy
* Moving and Handling Policy
* Nutrition and Hydration Policy
* Personal Care Policy
* Person-Centred Care Policy
* Prevention of Pressure Ulcers Policy
* Urinary Catheterisation Policy
* Wound Management Policy

# Legislation and Guidance

**Relevant Legislation**

* Mental capacity act 2005
* Health and Social Care Act 2008

**Guidance**

* Headway, the brain injury association (2019): The effects of brain injury and how to help
* NICE Clinical Guideline [CG176]: Head injury: assessment and early management
* Scottish Intercollegiate Guidelines Network (2013): Brain Injury rehabilitation in adults; A national clinical guideline

# Summary of Review

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