THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Nursing Service Guideline
General

Title: **SAFETY MANAGEMENT OF THE TRAUMATIC BRAIN INJURY (TBI) OR CLOSED HEAD INJURY (CHI)**

Description/ Purpose: To protect the patient's rights, to provide for the least restrictive environment, and to provide guidelines for safe and appropriate use of net beds in the treatment of Traumatic Brain Injuries and Closed Head Injuries.

Equipment: Net Bed, gait belts, wheelchair seat belts, bed alarms, other least restrictive devices

Procedure: Medical Assessment:

- Assessment and correction of underlying medical conditions including iotrogenic causes (especially drugs) which may propagate this acute state of confusion.
- Use of medications to enhance or speed cognitive recovery.
- Appropriate pain management.
- Correction of sleep-wake cycle abnormalities.

Points of Emphasis: People with acute brain disorders (TBI, subarachnoid hemorrhage, cerebral tumors, CHI) often undergo a period of acute confusion state/delirium in the process of their recovery. This is a transient medical condition seen in association with post-traumatic amnesia in the trauma setting. Management of patients in this phase of recovery is interdisciplinary involving medical, nursing and therapy services.

Procedure	Points of Emphasis
1. The following baseline data should be assessed by the RN as presenting a safety risk to the patient prior to considering interventions including restraining devices: ▪ Fall risk potential ▪ Cognitive functioning ▪ Memory problems ▪ Disorientation/confusion ▪ Impaired judgement ▪ Impulsiveness ▪ Weakness/paralysis ▪ Current medications ▪ Potential or actual fluid and/or electrolyte imbalance ▪ Deformities or medical conditions that would contraindicate use of restraining devices and/or warrant more careful monitoring.	Assessment should be done on all patients on admission, and ongoing as needed to prevent patient harm. Refer to the "Fall Assessment" section in daily charting, and Hospital Administration Policy 3364-100-53-12 on restraints. Consider any change in patient condition that may warrant Physician notification, as cause may require immediate medical treatment. Examples are (but not limited to): Restlessness may be from hypoxia, brain injury, metabolic/endocrine disorders etc. Confusion may be a symptom of hypoxia, hypotension, stroke, TIA, brain injury, hypoglycemia, etc.
2. Document and inform patient care providers assessment findings of above assessment.	
3. Consider least restrictive alternative measures and implement as appropriate.	There may be situations when alternative measures are not possible due to the patient condition (i.e., a violent patient). In these situations, documentation as to why least restrictive measures were not attempted must be made in the medical record.

Procedure	Points of Emphasis
4. Least restrictive alternative measures to consider: ▪ Placement of patient close to the nursing station (room or chair) ▪ Availability of a sitter/Family Sitter Program ▪ Increased frequency of observation or direct continuous observation 1:1 care ▪ Placement of the call light within the patient's reach ▪ Placement of the side rails in the up position and the bed in the low position as needed based on assessed need. ▪ Consultation with the physician regarding possible medication changes ▪ Decreasing sensory stimulation, (i.e. lowering lights, or decreasing noise) ▪ Bed alarms and chair alarms ▪ Participation of family in care process ▪ Diversional activities such as TV or music	
5. Restraint requiring time-limited orders: ▪ RN obtains time-limited order for non-violent or violent restraint ▪ Refer to Restraint policy #3364-100-53-12	Net beds utilized for the treatment of a CHI or TBI that presents a risk for harm to patient or to others requires a timed physician order. ▪ When obtaining a time-limited order, include date, time, type or restraints, location and specific reason for the restraint. ▪ The patient needs to be reevaluated every calendar day and only if needed are restraints reordered.
7. Care of the patient in net bed. a. Inform patients and families rationale for net bed and necessary changes in patient behavior and/or condition to discontinue. ▪ Rationale for the use of the net bed includes: ▪ Patient Safety ▪ Medications that potentially impair functioning ▪ Behavioral condition ▪ Impaired cognitive functioning.	Clarify with family the patient condition that warrants use of the net bed. Continue to comfort, reassure and offer explanation to patients and families. Families can also be offered the chance to participate in the family sitter program to decrease the time needed for a patient to be in a net bed.
b. Document in the medical record. ▪ The behavior and/or condition that warrants the need for the net bed. ▪ The least restrictive interventions utilized. ▪ A physical assessment of the patient to determine the appropriateness of restraints.	Document at least q shift, behavior that warrants continued need for the net bed. Maintain respect and privacy as much as possible.
c. Nursing care to be provided while the patient is in a net bed and its documentation at least q 2 hours: ▪ Respiratory/circulation status ▪ Emotional and supportive care provided	Unsafe items include but are not limited to: Smoking materials, sharp objects, medications and other potentially dangerous materials. Any redness bruising or changes in patient condition need to be reported to the physician and documented.

Procedure	Points of Emphasis
▪ Fluid and foods offered ▪ Toileting offered at least every two hours ▪ Skin care/attention given to skin, turning repositioning, offer bathing every 24 hours and more frequent hygiene as needed. ▪ Elevate head of bed to reduce the possibility of aspiration ▪ Remove unsafe objects from patient's reach	
8. Discontinuation of the net bed: a. A net bed will be discontinued when the patient no longer presents a risk for harm to self or others. This would mean prior to the expiration. b. If assessment warrants early release from the net bed, rationale for discontinuation could include: ▪ Availability of sitter ▪ Behavioral changes ▪ Least restrictive measures that were successful c. When discontinuing the net bed: ▪ Note time discontinued ▪ Note behavior of patient ▪ Rationale for discontinuing ▪ Status of the patient following removal up to the first sixty minutes d. When the net bed is terminated early and the same reason for the net bed is still evident, a new order must be obtained if alternatives are ineffective.	Because restraints can affect the dignity of patients, as well as causing harm, the decision to restrain or not should be discussed during team conference. Document: Date and time of every episode of application or discontinuation of restraints.

Revised by: Mike Drake, BSN, RN.
Resource: UTMC Restraint Committee

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References: 2022 CMS Standards
Joint Commission Provision of Care Standards 2022