

NURSING SERVICES GUIDELINE GENERAL

Guideline: Safety management of the traumatic brain injury (TBI) or closed head injury (CHI)



Policy Number Superseded:

Effective Date:
December 2025

Responsibility: Registered Nurse (RN)

Initial Effective Date:
December 2002

Purpose of Guidelines: 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:

- (1) Net bed
- (2) Gait belts
- (3) Wheelchair seatbelts
- (4) Bed alarms
- (5) Other least restrictive devices

Procedure: Medical Assessment

- (1) Assessment and correction of underlying medical conditions including - iatrogenic causes, especially drugs, which may propagate an acute state of confusion.
- (2) Administration of medications to enhance or expedite cognitive recovery.
- (3) Appropriate pain management.
- (4) Correction of sleep-wake cycle abnormalities.

Points of Emphasis: People with acute brain disorders such as TBI, subarachnoid hemorrhage, cerebral tumors, and CHI, often exhibit a period of acute confusion state and/or 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 the recovery phase is interdisciplinary involving medical, nursing and therapy services.

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PROCEDURE	POINTS OF EMPHASIS
<p>(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:</p> <ul style="list-style-type: none"> (a) Fall risk potential. (b) Cognitive functioning. (c) Memory problems. (d) Disorientation/confusion. (e) Impaired judgement. (f) Impulsiveness. (g) Weakness/paralysis. (h) Current medications. (i) Potential or actual fluid and/or electrolyte imbalance. (j) Deformities or medical conditions that would contraindicate the use of restraining devices and/or warrant specialized or specific monitoring. 	<p>Assessments should be done on all patients upon admission, and ongoing as needed to prevent patient harm. Refer to the "Fall Assessment" section in daily charting, and Restraints policy 3364-100-53-12.</p> <p>Assess for changes in patients' conditions that may warrant physician notification.</p> <p>Examples of such changes in conditions include , but are not limited to the following: Restlessness may be a symptom of hypoxia, a brain injury, and/or metabolic/endocrine disorders. . Confusion may be a symptom of hypoxia, hypotension, stroke, TIA, brain injury, and/or hypoglycemia.</p>
<p>(2) Document and inform patient care providers of assessment findings..</p>	
<p>(3) Consider least restrictive restraint alternative measures and implement as appropriate.</p>	<p>There may be situations when alternative measures are not possible due to the patient condition (i.e., a violent patient). In these situations, documentation why least restrictive measures were not attempted.</p>
<p>(4) Least restrictive restraint alternatives to consider:</p> <ul style="list-style-type: none"> (a) Placement of patient close to the nursing station (room or chair). (b) Increased frequency of observation or direct continuous observation 1:1 care. (c) Placement of the call light within the patient's reach. (d) Placement of the side rails in the up position, and the bed in the low 	

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<p>position, as needed, based on assessed need.</p> <ul style="list-style-type: none"> (e) Consult with physician regarding medications appropriate for circumstance. (f) Decreasing sensory stimulation, (i.e. lowering lights, decreasing noise). (g) Bed alarms and chair alarms. (h) Participation of family in care process. (i) Diversional activities such as TV or music. 	
<p>(5) Medical restraint use per timed-timed order. RN obtains time-limited order for non-violent or violent restraint. Refer to Restraint policy 3364-100-53-12.</p>	<p>Net beds utilized for the treatment of a CHI or TBI that present a risk for harm to patient or to others, requires a timed physician order.</p> <ul style="list-style-type: none"> ▪ When obtaining a time-limited order, include date, time, type or restraints, location and specific reason for the restraint. ▪ The patient needs to be re-evaluated every calendar day, if medical restraints continue to be and thus, reordered.
<p>(6) Care of the patient in net bed.</p> <ul style="list-style-type: none"> (a) Inform patients and families of the rationale for net bed and necessary changes in patient behavior and/or condition to discontinue. Rationale for the use of the net bed includes: <ul style="list-style-type: none"> ▪ Patient safety. ▪ Medications may potentially impair functioning. ▪ Behavioral condition. ▪ Impaired cognitive functioning. (b) Document in the medical record. <ul style="list-style-type: none"> ▪ The behavior and/or condition that warrants the need for the net bed. ▪ The least restrictive interventions attempted and utilized. ▪ A physical assessment of the patient 	<p>Clarify with family the patient condition that warrants use of the net bed.</p> <p>Continue to comfort, reassure and offer explanation to patients and families.</p> <p>Document at least q shift, behavior that warrants continued need for the net bed.</p> <p>Maintain respect and privacy as much as possible.</p> <p>Unsafe items include, but are not limited to: smoking materials, sharp objects, medications and any other potentially dangerous deemed materials.</p>

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<p>determining the appropriateness of restraints.</p> <p>(c) Nursing care to be provided while the patient is in a net bed and its documentation at least q 2 hours:</p> <ul style="list-style-type: none">▪ Respiratory/circulation status.▪ Emotional and supportive care provided.▪ Fluid and foods offered.▪ Toileting▪ 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.	<p>Any redness bruising or changes in patient condition need to be reported to the physician and documented.</p>
<p>(7) Discontinuation of the net bed.</p> <p>(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.</p> <p>(b) If assessment warrants early release from the net bed, rationale for discontinuation could include:</p> <ul style="list-style-type: none">▪ Behavioral changes.▪ Change in medical condition▪ Least restrictive measures that were successful. <p>(c) When discontinuing the net bed, document the following</p> <ul style="list-style-type: none">▪ Time discontinued.▪ Behavior of patient.▪ Rationale for discontinuing.▪ Status of the patient following removal for the first hour.	<p>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.</p> <p>Document: Date and time of every episode of application or discontinuation of restraints.</p>

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(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.	
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References: 2026 CMS Standards
Joint Commission Provision of Care Standards 2026

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Initial effective date:
December 2002

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Review/Revision Date:
December 2025

Next review date:
December 2028