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# Clinical consult column

*Dear Editor*

We are having trouble with an 18-year-old patient on our rehabilitation unit who had a severe brain injury. This gentleman has severe orthopedic injuries including broken bones in both legs. He is not ambulatory. Unfortunately, he remains disoriented and irritable. He lunges for female staff members when they care for him and often screams for no apparent reason. On a number of occasions we've had to put him in restraints, especially because we're concerned that he'll attempt to leave bed and try to walk. We're having problems with his family who told us that putting him in restraints or giving those 'terrible drugs' are unacceptable. When he gets irritable in his family's presence, his father yells at him and shakes his fist. The father has repeatedly told staff that he's successfully disciplined his son and 'raised him right'. Staff are also concerned about a possible accident. Several times the patient has been released from his restraints, and not by staff members. What do you recommend?

*T.C.*
Raleigh, North Carolina

*Dear T.C.*

I'm not surprised you're having difficulty — I've isolated 8 distinct problems outlined in your letter. A large part of the solution lies in family education. Families feel most comfortable, and are easiest to interact with, when they understand exactly what is going on with their loved one, and they know exactly what to do to deal with a problem. Remember this is likely their first experience with a brain-injured adult. Your knowledge comes from time and experience. Arrange for the family to meet with member's of the treatment team to discuss the best way to communicate with the patient, the patient's cognitive deficits and their implications, behavioral issues and medical status. Try to enlist the family as an ally rather than see them as the enemy or harming the patient. The rest of the solution lies in modifying staff and family behavior. Keep in mind that the onus for change is not on the patient in this case. Expectations for behavioral control must be lowered, given the patient's severe cognitive deficits. Let's deal with the problems one by one. Here goes....

*(1) Restraints*

Restraints are medically necessary in this case. A clear message should be given to the family by the physiatrist or orthopedic specialist, about the short- and long-term consequences of weight bearing/ambulation at this time. Combining this information with information about the patient's cognitive deficits (e.g. inability to understand or remember the information) should make the necessity for restraints clearer to the family. The family should be confronted if they remove re-


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straints and the restraints reapplied. Staff must agree to send a consistent message to the family or they will continue to remove the restraints. The family should be reassured that the restraints will be discontinued as soon as the patient is no longer a safety risk. Consider whether a posy vest alone would suffice for this patient. Sometimes patients can be managed adequately with only two or three point restraints which may make the family more comfortable. It may also be helpful to try to involve the family here. Could the patient go without restraints while in bed if he is being supervised by a family member? Perhaps the family could arrange to stagger their visits instead of visiting all at once.

*(2) 'Terrible drugs'*

When this subject arises ask the family member exactly which medication they mean and move into education. Tell them the name of each drug the patient is taking and what it's for. Talk about the likely length of time the patient will be on the drug. Try to enlist the family's help as observers. Do they see any improvement in the patients behavior? Will they report back in a few days?

*(3) Father repeatedly telling staff he has successfully disciplined his son and 'raised him right'*

Families that give this message are usually highly embarrassed about their loved one's behavior. Let the father know that you believe him. Ask him what his son was like before. Tell him that his son's behavior is typical, and that you've seen it many times before in other patients at this stage of recovery. Stress that you know it's not willful and that you expect it to pass as cognition improves.

*(4) Father yells at him and shakes his fist*

What may be happening here is that the father is very angry about his son's unacceptable behavior, and is attempting to 'lay down the law' as he may have done in the past. He is likely frustrated about his son's 'unwillingness' to obey. Tell the father that the rules have changed, and once again outline the patient's cognitive deficits — particularly those that make it difficult for the patient to modify his behavior on command. Model for him how to respond to his son's behavior. Tell him the behavior will improve if structure and consistency are provided and overstimulation avoided.

*(5) Lunges for female staff*

This behavior appears to be sexual disinhibition. An alternative explanation would be that the patient is looking for reassurance. In any case the behavior is inappropriate. It would be a big mistake to ignore it, for if it were to continue it would greatly reduce the chances of the patient's social acceptance after discharge. The behavior should be consistently greeted with statements like, 'Don't grab, that's inappropriate' given in a stern voice. Giggling or showing embarrassment should be discouraged. Would it be possible to assign male nurses to the patient more frequently? Or more experienced female nurses?

*(6) Screams for no apparent reason*

There is a reason. Most likely the patient is afraid, or is in pain. Again the behavior must be reprimanded (e.g. 'Shouting is inappropriate'), but followed by calm reassurance. Would it be possible to give the patient some quiet company? Nurses could arrange to chart in the patient's room. Provide the patient with quiet familiar music to listen to. Are pain medications sufficient?

*(7) Disorientation*

Staff working with the patient should orient him frequently in a calm voice. This patient will require orientation to time and place *and* to exactly what is happening around him. All procedures and activities should be described in advance, in simple terms, and a rationale given if necessary, e.g. 'I'm taking off your socks. It's time to get ready for bed'.

*(8) Irritability*

Irritability is very common in brain-injured patients at this stage of cognitive recovery. The

behavior may mean that the patient has been overstimulated, or that his basic needs have not been met. Do what you can to modify the patient's environment. Limit television, number of visitors, and time off the unit. Staff not working with the patient should not greet him or interact with him. Is he hungry, in pain, hot? Does he have a wet diaper or need to be toileted?

The final thing to keep in mind is the toll such a patient and family can have on staff morale. Make sure staff are getting the breaks and support they need. Good luck!

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