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Theoretical Article

Telenursing as an intensive care strategy for a patient with traumatic acute subdural hematoma: an experience report

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Abstract

Introduction
Nursing care in intensive care units involves high-acuity clinical situations that require technical and scientific preparation, rapid clinical decision-making, and interprofessional practice. In the intensive care of patients with traumatic acute subdural hematoma, nurses play a central role in continuous monitoring and in implementing evidence-based interventions.

Objective
To report nursing students' experience during clinical practicum activities in an intensive care unit that used telenursing as a clinical support strategy for a patient with traumatic acute subdural hematoma.

Methods
This is an experience report conducted in March 2025 at a public, trauma-referral hospital in an inland city in Paraíba State, Northeast Brazil. The experience involved interstate coordination between two hospitals in different regions of Brazil to strengthen the care delivery process. A telenursing service was implemented to facilitate remote clinical discussions based on case presentation, enabling shared assessment of the patient's health status and joint planning of nursing interventions to improve the quality of care provided.

Results
Students actively participated in the telenursing session by presenting the clinical case and discussing key aspects of care with the nurse during a videoconference. This telenursing-facilitated practicum experience highlighted the tool's potential both to support clinical decision-making in complex clinical contexts and to serve as a teaching resource in nursing education.

Conclusion
When used as a clinical decision-support tool and as an educational strategy, telenursing demonstrated potential to help integrate theory and practice more dynamically. Such an experience enabled students to recognize this technology's relevance for care delivery and for expanding the reach of care, especially in high-acuity contexts

Keywords
Acute Subdural Hematoma; Telemedicine; Traumatic Brain Injury; Intensive Care Units.

Introduction

Nursing care delivered in intensive care units (ICUs) is among the most complex and demanding areas of professional practice, requiring specialized technical, scientific, and human competencies. ICUs care for critically ill patients who require continuous care, rigorous clinical assessment, and rapid interventions, often in response to sudden changes in clinical status.[1]

In this setting, nurses play a central role, leading the Nursing Process and working in coordination with the interprofessional team to promote safety, the quality of care, and comprehensive care.[2]

Among the conditions managed in ICUs, traumatic brain injury (TBI) is highly prevalent in Brazil, with a mean incidence of 65 cases per 100,000 population between 2008 and 2019.[3] One of the most common TBI-related complications is traumatic acute subdural hematoma (ASDH), characterized by blood accumulation in the space between the dura mater and the arachnoid membrane. It is a severe neurologic condition that can progress rapidly, leading to decreased level of consciousness, progressive neurological deterioration, coma, and, not uncommonly, death.[4-5]

Mortality rates associated with ASDH range from 50% to 90% and are influenced by factors such as age, pupillary abnormalities, Glasgow Coma Scale (GCS) score, and lesion extent and location.[6] For these reasons, ASDH is a public health problem.

In light of this, ASDH management is a high-priority clinical challenge for ICU nursing teams, which underscores the need for integrated, technology-enabled strategies for care delivery. In this context, care models that integrate information and communication technologies (ICTs), such as telenursing, have gained prominence as a way to strengthen the Nursing Process.

Within the broader umbrella of telehealth, telenursing uses digital technologies to provide remote care, consultation, education, supervision, and health monitoring.[7]

In this scenario, telenursing has become an innovative, strategic tool that expands nurses' scope of practice without altering its core. By enabling remote follow-up, case discussion, and shared care planning, this approach can support timely clinical decision-making, strengthen the quality of care, and reinforce care delivery within health networks, especially in situations requiring rapid response and specialized support, such as ASDH.[8]

Accordingly, undergraduate nursing programs should integrate educational experiences into their curricula that expose students to ICTs applied to clinical practice. This integration helps students develop clinical reasoning, evidence-informed decision-making, effective communication, and care management skills in settings that demand high-acuity interventions.[9]

In this regard, ICU practicums that incorporate telenursing are an essential teaching strategy: they immerse students in both the dynamics of intensive care and the use of health technologies, supporting their technical, ethical, and critical development.

Thus, this study aims to report nursing students' clinical practicum experience in an ICU that uses telenursing as a clinical support strategy in the care of a patient with traumatic acute subdural hematoma.

Methods

This qualitative, descriptive experience report draws on activities conducted during ICU clinical practicum sessions, which were part of the practical component of a required course in the undergraduate Nursing program at a federal public university located in an inland city in Paraíba State, Northeast Brazil. The experience took place in March 2025 at a high-acuity public hospital in the same city as the university, which serves as a referral center for urgent and emergency care.

The experience was carried out as part of an interstate collaboration to evaluate and strengthen care processes between two hospitals in different regions of Brazil. In this setting, a telenursing service was implemented to support remote clinical discussion through case presentation via a bedside videoconference. This approach enabled a shared assessment of the patient's health status and joint planning of nursing interventions aimed at improving the quality of care provided to a patient diagnosed with traumatic acute subdural hematoma.

The data underpinning this report were generated through students' participation in the telenursing session. Under the supervision of the ICU nurse and the faculty supervisor, students presented the patient's clinical status to the nursing team at the partner institution. During this session, the team discussed the patient's clinical progression, neurological monitoring, and complication-prevention strategies, and proposed adjustments to the planned nursing interventions.

In parallel, students participated actively in the patient's care, including conducting a systematic physical examination, monitoring clinical parameters, performing continuous neurological assessment, and implementing nursing interventions grounded in the Nursing Process. All activities were carried out under the

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faculty supervisor's guidance, ensuring patient safety and adherence to the ethical and legal principles governing professional practice.

Because this report is linked to teaching activities and did not involve the collection of sensitive data or direct research interventions with human participants, it did not require submission to a Research Ethics Committee. This is consistent with Brazilian National Health Council (Conselho Nacional de Saúde, CNS) Resolution No. 510/2016, as the report describes the authors' own experience.

Development

The experience occurred during the required clinical practicum of three undergraduate nursing students in the ICU of a public trauma-referral hospital in Paraíba, Brazil. The unit had 10 beds and, at the time, all were occupied; most patients were men admitted with TBIs resulting from motorcycle crashes. This pattern aligns with previous studies describing the predominant profile of ICU admissions in trauma-referral hospitals: men with TBIs caused by motorcycle crashes.[10-11]

Within the interprofessional team, two nurses were responsible for implementing the Nursing Process for critically ill patients in the unit. They used telenursing—an ICT-based modality—as a strategy for delivering care. Muniz, Mota, and Sousa (2023)[12] describe this approach as advanced nursing practice, which can support high-quality patient care.

Patient characteristics in light of the scientific literature

For academic purposes, a patient diagnosed with traumatic acute subdural hematoma was selected; the injury resulted from a fall while riding a horse. A clinical case analysis was conducted, and, subsequently, students' experience using telenursing during the care provided to this patient was described.

The literature indicates that TBI is associated with high morbidity and mortality worldwide. It results from an external physical force and is characterized as an injury to brain tissue from closed or open trauma that can compromise brain function, leading to physical, behavioral, cognitive, or emotional changes.[13]

ASDH, considered a type of extra-axial hemorrhage, is a recognized consequence of open TBI. It is defined as an accumulation of blood and clot formation between the meningeal layers—the dura mater and the arachnoid—typically due to rupture of cerebral blood vessels. In the present case, the ASDH was traumatic in origin, as it occurred after a fall; traumatic cases are reported to be more common than spontaneous ones.[4-5]

Patients' signs and symptoms vary across individuals and depend on the injury's severity and characteristics. They typically include an initial GCS score of 8 or less, dysarthria, confusion and memory impairment, transient loss of consciousness, coma, and posterior fossa hemorrhages.[15]

Progressive elevation of intracranial pressure (ICP) > 20 mmHg, along with brain compression, edema, and brain tissue injury, can precipitate cerebral herniation and brain shift, leading to dyspnea, bradycardia, and, in some cases, brain death and death.[16,17]

Prognosis is poorer among patients older than 65 years and in those with moderate to severe brain injury, nonreactive pupils, or a large hematoma with midline shift. These findings are strongly associated with mortality and with the need for neurosurgical intervention, although surgery may limit clinical deterioration. In the clinical case described here, the patient's physical findings aligned with the signs, symptoms, and prognosis described in the literature.[18]

Regarding ASDH treatment, Rathore et al. (2021) state that small hematomas may not require surgery, as the blood can be reabsorbed spontaneously with medical therapy and close clinical monitoring. Cerebral pulsatility and intracranial compliance may also contribute to the spontaneous resolution of this condition.[19]

By contrast, large clots generally require surgical evacuation; however, the indication depends on the patient's prognosis, including the extent of neurologic injury, clot thickness, degree of midline shift, GCS score, and ICP parameters, which guide decisions about the most appropriate interventions.[20]

In this setting, nursing care is essential, with continuous neurologic monitoring, clinical support, and support for the family to maintain stability and prevent adverse outcomes.

Nursing diagnoses identified in the patient

Given the clinical picture described above, nursing diagnoses are essential because they capture the patient's clinical complexity and the severity of neurologic and systemic compromise.[21] The following diagnoses were identified:

Ineffective cerebral tissue perfusion was prioritized, given signs of profound neurologic impairment (decerebrate posturing, nonreactive pupils, and a Richmond Agitation–Sedation Scale [RASS] score of −5), suggesting elevated ICP and an imminent risk of cerebral herniation.

In parallel, Impaired gas exchange and Risk for aspiration highlighted the respiratory vulnerability of a sedated patient who was unable to protect the airway, compounded by secretions and adventitious breath sounds on

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auscultation. Impaired physical mobility further increased the risk of secondary complications, including pressure injuries and venous thromboembolism.
In addition, Risk for infection was present, given prolonged hospitalization and multiple invasive devices. Early recognition of these diagnoses, coupled with targeted interventions, is critical to strengthen nursing care and prevent complications, underscoring the nurse's role in high-acuity settings.

Use of telenursing as a care delivery approach

In a high-acuity case such as ASDH, telenursing was used during the students' clinical practicum to support clinical decision-making and guide nursing interventions for this patient.
Toffoletto and Tello (2020) describe telenursing as a relevant health technology for healthcare services because it can help reduce regional disparities and improve quality across health promotion, prevention, diagnosis, treatment, management, information, and research.[22]
Accordingly, the ICU described in this experience report maintains a partnership with a large, nationally recognized hospital in southeastern Brazil. Through this partnership, daily videoconferences are held between the ICU staff nurse at the admitting hospital and a nurse affiliated with the partner institution.

Students' experience: actions, perceptions, challenges, and discoveries

During the practicum, students participated actively in the care process, providing direct care to the patient described in this report. Their activities included performing a physical assessment, administering medications, monitoring vital signs, and delivering nursing care. This immersion enabled close follow-up of the patient's clinical progression and helped students recognize the vulnerabilities and care needs typical of critically ill patients.
Students also actively participated in the telenursing session, which supported care delivery. A videoconference (average duration: 15–20 minutes) was held with a nurse from the partner, referral hospital. During the session, students, accompanied by the unit nurse, presented the patient's clinical status and discussed care-related interventions. The exchange was interactive: the consulting nurse prompted students' clinical reasoning by asking about causes, manifestations, and possible interventions, while also offering evidence-informed guidance and recommendations.
Students reported that the experience highlighted telenursing's relevance as a tool for expanding care reach and strengthening the quality of care. As this was their first exposure to this approach, it prompted reflection on the importance of maintaining a broader view of care delivery. The participation of a professional from another institution, with different clinical experience and practice patterns, was perceived as enriching complementing the local team's care and supporting safer, more comprehensive care.
Students also noted that, compared with clinical placements where telenursing was unavailable, telenursing-enabled care was perceived as more effective and collaborative, enabling more in-depth discussion and analysis of clinical cases.
In terms of challenges, the experience underscored the need for adequate infrastructure, particularly reliable connectivity to ensure stable videoconferences. It also highlighted technological limitations in some public services that operate as clinical training sites and still lack sufficient resources to implement similar tools. Students further recognized that broader interprofessional participation in these sessions could strengthen comprehensive care and support clinical decision-making.
Another point emphasized was the limited coverage of this care modality during undergraduate training. Therefore, within the practicum context, institutionalizing these experiences in the curriculum is recommended to enable more students to engage in practices that integrate science, technology, and humanized care.[23]
The most meaningful discoveries emerged from direct contact with the technology and its practical use within Brazil's Unified Health System (Sistema Único de Saúde, SUS). Both students were surprised to learn that telenursing is already established in public hospitals and that its use can effectively strengthen the quality of care. Overall, the experience was viewed as a formative milestone, showing that integrating science, technology, and humanized care is both feasible and essential to advancing contemporary nursing.

Conclusion

Providing telenursing-supported care to a patient with ASDH in the ICU proved to be a meaningful and innovative learning experience for nursing students. Direct participation in videoconferences and interaction with a professional from a referral institution supported the development of clinical, communication, and reflective competencies, strengthening students' ability to critically analyze complex situations and base their interventions on evidence.

In this context, when used both to support clinical decision-making and as a pedagogical strategy, telenursing showed potential to more dynamically bridge theory and practice. This experience also enabled students to recognize this technology's relevance as a care tool and as a means of expanding care reach, particularly in high-acuity settings.
These learning outcomes reinforce the importance of incorporating technology-mediated practices into nursing education—especially telenursing—to foster knowledge development focused on innovation and humanized care. Looking ahead, quantitative studies and replications in other care settings are recommended to assess telenursing's pedagogical and clinical impact on nurses' training and professional practice.

Study limitations
This experience was conducted in a single institutional setting and involved only one patient, which limits the generalizability of the findings. In addition, the lack of systematic assessment instruments made it difficult to objectively measure learning outcomes. Despite these constraints, the experience offered relevant insights into telenursing's pedagogical and clinical potential, serving as a foundation for future investigations in other contexts and on a broader scale.

Authorship and Contributions
L.M.B.: Study conception and design; data collection, analysis and interpretation; manuscript writing and critical revision, approval of the final version and responsibility for the manuscript;
A.L.M.D.: Study conception and design; data collection, analysis and interpretation; manuscript writing and critical review, approval of the final version and responsibility for the manuscript;
R.M.O.B.: Study conception and design; data collection, analysis and interpretation; writing and critical review of the manuscript, approval of the final version and responsibility for the manuscript;
T.C.F.A.: Data collection; critical review of the manuscript; approval of the final version and responsibility for the manuscript;
E.M.N.: Critical review of the manuscript; approval of the final version and responsibility for the manuscript;
M.K.T.L.: Approval of the final version and responsibility for the manuscript;
A.O.B.S.: Approval of the final version and responsibility for the manuscript.

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Data availability statement
Data openly available in a public repository that issues datasets with DOIs.

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