St. George Hospital Trauma Committee

GUIDELINES FOR SEVERE PAEDIATRIC TRAUMA STABILIZATION AND TRANSFER

Approved by the SGH Trauma Committee June 2004

AIM

The aim of these guidelines is to provide severely injured paediatric patients with optimal multidisciplinary clinical care prior to their transfer to a specialized Paediatric Trauma Centre.

JUSTIFICATION

Since the St George Hospital (SGH) is not a paediatric trauma centre, ambulance services preferentially deliver the most severely injured children to the designated Area Paediatric Trauma Centre. Occasionally, however, severely injured children will arrive at the SGH Emergency Department due to their imminent risk of death or because they are transported by private vehicle. SGH must therefore have an established response to stabilize such patients and provide life-saving interventions prior to their transfer to the Area Paediatric Trauma Centre for definitive care. This capability will necessarily involve various clinical services, including but not limited to Paediatric Surgery, Paediatrics, Neurosurgery, Orthopaedic Surgery, Anaesthesia, Intensive Care, and Emergency Medicine.

GUIDELINES

1. The **ED Trauma Team Leader** will be responsible for the early identification of paediatric patients whose injuries or potential injuries merit transfer to a paediatric trauma centre. This determination will often be made after consultation with the on-call Paediatric Surgeon, Neurosurgeon, or Orthopaedic Surgeon.

    a. The on-call Paediatric Surgeon should be promptly notified of all severely injured paediatric patients arriving in the trauma resuscitation room.

2. The **Paediatric Surgeon** will be responsible for determining the need for emergency surgical intervention at the SGH. When neurotrauma is present, this responsibility will fall to the on-call **Neurosurgeon**. Similar responsibility will fall to the **Orthopaedic Surgeon** if there are injuries requiring emergency orthopaedic stabilization. Should the patient have multiple indications for surgery by two or more surgical specialists (eg,: subdural hematoma and ruptured spleen), the ultimate decision on the order and timing of surgery will fall to the on-call Paediatric Surgeon.

    a. Close and frequent communication between the various relevant surgical specialties, at a consultant level, is essential to the process of setting rational and safe surgical priorities.

3. Early involvement by the **Paediatrics Service** in the multidisciplinary care of the severely injured child may often be desirable, and will be at the discretion of the senior clinician(s) involved in the patient's care.

4. Early involvement by the **Anaesthesia Service** is mandatory, as frequently these patients will either have complex airway problems or will require emergency surgery in the operating theatre. Since the on-call anaesthetist is automatically notified by the current trauma paging system of all arriving trauma patients, his/her attendance at the trauma resuscitation is usually assured.

    a. Should the on-call anaesthetist determine that he/she requires the input/assistance of a second anaesthetist or of one with more paediatric anaesthesia experience, he/she will have the option to call in either the back-up on-call anaesthetist or one of several anaesthetists designated by the Department of Anaesthesia as "Paediatric Anaesthesia Specialists."

5. Early involvement by the **Intensive Care Service** is mandatory, as frequently these patients will require ICU care prior to their transfer to the Paediatric Trauma Centre. Since the on-call ICU resident / registrar / fellow is automatically notified by the current trauma paging system of all arriving trauma patients, his/her attendance at the trauma resuscitation is usually assured.

    a. It will be the responsibility of the ICU resident / registrar / fellow who responds to the trauma page to promptly contact the on-call ICU consultant when it appears likely that the child will require ICU admission.

6. The location of any postoperative care (eg.: PACU, ICU, etc.) will be determined by the Anaesthesia and ICU consultants.

7. The **Paediatric Retrieval Service** should be notified of an impending transfer to the Paediatric Trauma Centre as soon as the decision for transfer has been made. The senior clinician(s) involved in the patient's care will communicate with the Retrieval Service to communicate the specifics of the patient's condition and to establish the transport requirements.

8. The timing of the patient's transfer will be decided via consensus between the Surgery, ICU, Anaesthesia and Emergency Medicine consultants.

9. It is imperative that the subspeciality medical personnel at the receiving Paediatric Trauma Centre accept care for the child and obtain accurate and timely reports of the patient's medical history and progress prior to transfer. All relevant nursing and medical personnel should communicate directly with their counterparts at the receiving facility in order to assure that important information is not overlooked or misinterpreted. Additionally, the following items should accompany the patient on transfer:

    a. a complete photocopy of the medical record
    b. digital or 'hard' copies of any relevant radiologic studies

10. It is understood that all medical and nursing staff attending to critically ill paediatric trauma patients at SGH are providing a service that is often beyond their expertise and job description, but is necessary and appreciated in the unique circumstances outlined above.