PEDIATRIC TRAUMA ASSESSMENT

In the trauma patient, time is critical. Only initial assessment and treatment of life-threatening injuries should be performed on scene. For severely injured patients, after appropriate airway management, "load and go" is more appropriate.

If dispatch information gives the responding ambulance reason to suspect the possibility of a significant accident situation (multiple vehicles, etc.), alert **Medical Command** prior to arrival at scene and consider aeromedical standby.

A. Scene evaluation:

   1. Note potential hazard to rescuers and patient.

   2. Identify number of patients and organize triage operations, if needed.

   3. Observe patient position and surroundings.

   4. Consider need for ALS and/or aeromedical evacuation.

B. Consider mechanism of injury:

   1. Cause, precipitating factors, and weapons used.

   2. Trajectories and forces involved to patient.

   3. For vehicular trauma: condition of vehicle, windshield, steering wheel, compartment intrusion, car seat, type and use of seatbelts. Specific description of mechanism (i.e. auto-pole, rollover, auto-pedestrian, etc.).

   4. Helmet use?

C. Patient assessment:

   1. Determine responsiveness.

      a. Establish and maintain airway.

      b. Maintain C-spine.

      c. Perform **Airway Management Protocol 6901,** as indicated.

   2. Breathing:

      a. If adequate, oxygen 15 LPM nonrebreather mask to maintain SpO2 at 94 - 99%.

b. If inadequate, ventilate with 100% oxygen and perform **Airway Management Protocol 6901,** as indicated.

3. Circulation:

a. Control bleeding.

b. Assess perfusion status.

4. Neurological status:

a. Determine level of consciousness using AVPU or GCS.

b. Check pupils.

5. Limit on-scene time. Unless unusual circumstances, the goal should be:

a. Not trapped: 10 minutes or less.

b. Entrapped: within five (5) minutes of extrication.

6. In **consultation with Medical Command**, establish mode (ground vs. air) and destination of transport.

D. Treatment:

1. Immobilize patient on long spine board or as indicated in **Spinal Trauma Protocol 6103**.

Note: All multiple trauma patients are considered to have a significantly distracting, painful injury. Infants and toddlers with minor injuries or no apparent injury may be left in child safety seats and immobilized, provided the seat is undamaged.

2. Transport.

3. Monitor vital signs and continue treatment en route.

4. If any signs of shock such as tachycardia, tachypnea, cool/clammy skin, low blood pressure, or high suspicion of major blood loss refer to **Pediatric Hypoperfusion / Shock Protocol 6402.**

5. Prevent heat loss.

6. Request ALS backup if needed and not already completed and contact

Medical Command.