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 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 vs pole, rollover, auto vs 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 4901,** as indicated.
2. Breathing:
   a. If adequate, oxygen 15 LPM non-rebreather mask to maintain SpO2 at 94 - 99%.

b. If inadequate, ventilate with 100% oxygen and perform **Airway Management Protocol 4901,** 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 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 4103**.

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. Pediatric patients 10 – 40 lbs, not in a viable car seat, shall be transported utilizing an approved method of securing the child.*

2. Transport.

3. Monitor vital signs, obtain ECG, and monitor pulse oximeter.

4. If child has significant injuries or mechanism for significant injury, establish at least one IV line of normal saline with as large a catheter as possible up to a 14 gauge.

a. If any signs of shock such as tachycardia, tachypnea, cool/clammy skin, or low blood pressure, or high suspicion of major blood loss, administer 20 ml/kg normal saline IV bolus and refer to **Pediatric Shock Protocol 4402**.

b. If patient has no signs or symptoms of shock, maintain normal saline IV at KVO.

5. Prevent heat loss.

6. Consider nasogastric tube placement if patient is intubated and has no facial trauma.

7. Refer to **Pain Management Protocol 4902,** if indicated.

8. Notify **Medical Command**.