PEDIATRIC TRAUMA MAP

The pediatric trauma patient presents a unique set of injuries that requires the mobilization of multiple resources to ensure optimal care in a timely manner. Coordination of these resources with a sound understanding of the roles that each service provides is essential as the overall care of the patient is complex and extremely time sensitive. Coordination of the resuscitation of the traumatized pediatric patient must be carried out concurrently with arrangement of the final disposition of the patient. This is extremely important due to the resources required for the transfer of the patient to a center that specializes in pediatric trauma. The Pediatric Trauma Map has been developed to assist all of those involved with a pediatric trauma to understand their individual roles within a Trauma Team. The common end point is high quality patient care provided in a comprehensive and efficient manner.

The resources required for the pediatric trauma patient are extensive and the role that each health care provider on the Trauma Team plays must be clear to provide efficient care and ensure all aspects of care are identified and addressed. The following are general principles to be followed within the Pediatric Trauma Care Map:

1) The TTL and ED Charge Nurse are at the center of care
2) The TTL coordinates all resources required for the overall trauma care of the patient
3) The Charge nurse assists the TTL and coordinates all other aspects of care
4) The TTL and Charge Nurse ensure all appropriate resources within the Trauma Team are activated
5) ORNGE is to be contacted as soon as the potential for transfer to a higher level of care is identified. This may occur as early as information from dispatch or paramedics indicates the potential of a significant pediatric trauma. (pediatric patients 12 years and under)
6) The Pediatrician is responsible for providing the overall medical care for the patient from a pediatric perspective. This includes communication with the Pediatric Critical Care Resource (PCCR) Team.
7) The PCCR Team is contacted using Criticall (1-800 668-HELP (4357) and should be utilized early in the care of the patient.
8) The preferred pediatric trauma care center for TBRHSC is London.
9) If the TTL involves ICU, the on call intensivist can be contacted AND Dr Brown, Dr Stallwood or Dr Scott (intensivists with pediatric ICU interest) should be contacted directly (even if not listed as "On Call")
10) In general, if it is determined that the pediatric patient requires admission to the ICU, transfer to a Pediatric Trauma Center should have already be considered.
11) There should be a low threshold for transfer of the pediatric patient to a Pediatric Trauma Center
12) Once transfer of the patient is identified, the patient will remain in the ED if the estimated time for arrival of ORNGE is less than 2 hours. If arrival of ORNGE is greater than 2 hours, the patient will be admitted to ICU to await transfer to a pediatric facility.
13) If the patient is awaiting transfer in the ED, the TTL, pediatrician and intensivist will jointly identify the MRP and if transferred to the ICU the pediatric intensivist (DR's Brown, Scott or Stallwood) will be the MRP. If all three are unavailable MRP should be pediatrician with anesthesia providing airway management.
14) If transferred to the pediatric ward with a simple single system injury, the MRP will be consensually determined by the system of injury (with the pediatrician providing supportive care.) If there is more than one system involved the Trauma Service MRP will be the MRP with the pediatrician and specialist(s) providing concurrent care.

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