

Hunter New England Health – Southern Sector  
**PAEDIATRIC HEAD INJURY MANAGEMENT**  
 in EMERGENCY DEPARTMENTS

Name \_\_\_\_\_  
 MRN \_\_\_\_\_

Triage: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Priority: \_\_\_\_\_ Area: \_\_\_\_\_ Interpreter Required: \_\_\_\_\_

Triager Name (Print): \_\_\_\_\_ Triager Signature: \_\_\_\_\_

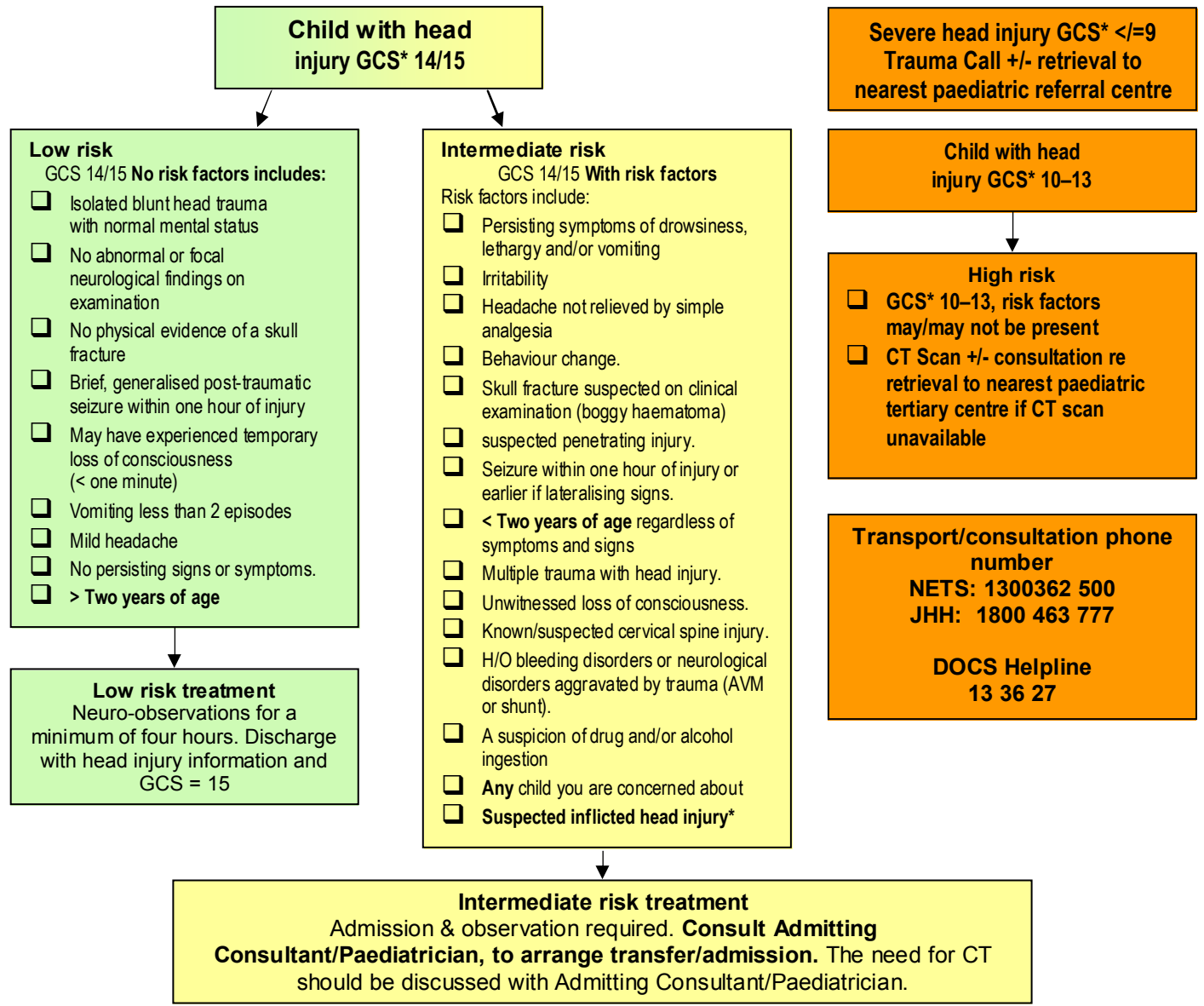
**ASSESSMENT**

Weight: \_\_\_\_\_

Apply a semi-rigid collar to protect the cervical spine if the mechanism of injury warrants or if the mechanism of injury is unclear.

Paediatric Coma Scale: Score each category according to table over page. Total score out of 15 = \_\_\_\_\_

NOTE: Any tick in a higher category assign to that category.



Triage Nurse: RISK SCORE  Low Risk  Intermediate Risk  High Risk/Severe Signed: \_\_\_\_\_  
 Doctor: RISK SCORE  Low Risk  Intermediate Risk  High Risk/Severe Signed: \_\_\_\_\_

\*If inflicted head injury is suspected then there should be communication with the paediatric referral centre to discuss the indicators of the case. If it is agreed that it is a suspected case of inflicted head injury then transfer to the paediatric referral centre should occur. DoCS should immediately be notified of the suspicion and the transfer.

| PAEDIATRIC COMA SCALE – Score each category according to age as below. Total score out of 15 |                       |      |                            |                             |                         |                                    |                      |
|--|-----------------------|------|----------------------------|-----------------------------|-------------------------|------------------------------------|----------------------|
|  |                       | 1    | 2                          | 3                           | 4                       | 5                                  | 6                    |
| <b>Eye Opening</b>   | <b>All ages</b>       | None | To pain                    | To speech                   | Spontaneously           |                                    |                      |
| <b>Best Verbal</b>   | <b>0 – 23 months</b>  | None | Grunts, agitated, restless | Persistent cries, irritable | Cries but is consolable | Smiles and coos, fixes and follows |                      |
|  | <b>&gt; 23 months</b> | None | Incomprehensible sounds    | Inappropriate words         | Confused                | Orientated (aware in hospital)     |                      |
| <b>Best Motor</b>  | <b>&lt; 1 year</b>    | None | Extension                  | Flexion – abnormal          | Flexion - withdrawal    | Localise pain                      | Spontaneous movement |
|  | <b>&gt; 1 year</b>    | None | Extension                  | Flexion - Abnormal          | Flexion - withdrawal    | Localise pain                      | Obeys                |

Adapted from Royal Children's Hospital, Melbourne. Head Injury Clinical Practice Guideline, Paediatric Modified GCS, 2006.

#### INDICATIONS FOR CAT SCAN

All with GCS  $\leq$  13  
 ALL with GCS not returning to 15 within 2 hours  
 Suspected Skull #  
 Penetrating injury  
 High risk mechanism/bleeding disorder

| Age (yrs) | BP (systolic) | HR (/min) | RR (/min) |
|-----------|---------------|-----------|-----------|
| <1        | 70-90         | 110-160   | 30-40     |
| 1 – 2     | 80-95         | 100-150   | 25-35     |
| 2 – 5     | 80-100        | 95-140    | 25-30     |
| 5 – 12    | 90-110        | 80-120    | 20-25     |
| >12       | 100-120       | 60-100    | 15-20     |

#### Observations:

- Monitor pulse, respirations, BP, Spo2 and GCS at least 30 minutely.