

Arizona Emergency Medical Systems, Inc.

**RED BOOK
CHAPTER 5**

**Triage: PEDIATRIC
Pediatric Emergencies Triage Guidelines**

DISCLAIMER

This Manual sets forth procedures and protocols deemed by AEMS to be within the acceptable standard of medical care. It is specifically recognized that there are acceptable variations from these procedures and protocols, which may also satisfy the standard of care. Therefore, variations from these procedures and protocols are not necessarily deemed to be outside the standard of care. This manual does NOT define, limit, expand or otherwise purport to establish the legal standard of care.

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PEDIATRIC TRIAGE

Designated pediatric Emergency Departments:

- Desert Samaritan (southeast sector)
- Maricopa Medical Center (central sector)
- Phoenix Children's Hospital (central sector)
- St Joseph's Hospital (central sector)

Purpose:

Triage Guidelines are intended for use by certified EMTs, IEMTs, and Paramedics when encountering and caring for critically ill or injured patients in the Central Arizona Regional EMS System. In all cases, the health and well being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; and requests by the patient, family or physician.

Procedure:

1. Triage guidelines should be implemented after evaluation and attempted stabilization of the patient. Triage guidelines are not meant to address all components of prehospital care. Consultation with Medical Control may be necessary to assist in triage decisions.
2. If ALS personnel are not available, initial stabilization should be implemented and the patient transported to the closest appropriate categorized general emergency department (ED).
3. Patient choice is a primary consideration in the triage decision. If the parent/patient is unable to make a reasonable choice, or the medical condition of the patient requires a specific level of care, destination may be determined by Medical Control.
4. Pediatric patients may be transported to a non-pediatric emergency department center provided all the following is met:
 - The patient, family or private physician requested transport to a non-pediatric emergency facility.

General Medical Emergencies:

1. Pediatric patients assessed to be in stable* condition may be transported to the closest appropriate categorized general ED.
2. Pediatric patients assessed to be in unstable* condition will be transported to the closest appropriate pediatric categorized ED**.

Note:

Unstable patients meeting criteria for transport to a pediatric categorized ED

- Shall be transported to the most accessible pediatric ED if ground/air transport is 30 minutes or less.
 - If ground/air transport time to a pediatric ED is greater than 30 minutes; the patient may be transported to the most accessible categorized general ED.
3. Pediatric patients in critical condition (arrest +/- inability to establish an airway) will be transported to the closest appropriate categorized general ED.

*Definitions:

Stable patient: patient with a single or well-defined chief complain(s), that after initial intervention is:

- without neurological, respiratory, and/or cardiovascular compromise
- responding favorably to initial treatment (i.e., resolving or improving s/s)

Unstable patient: Any patient with a single, multiple system, or complex chief complaint with or without hemodynamic compromise that does not respond favorably to initial treatment.

Examples include:

- Cardiac dysrhythmia
- Severe respiratory distress
- Cyanosis
- Persistent altered mental status
- Status epilepticus
- ALTE (Acute Life Threatening Event) \leq 12 months of age
- Signs of meningitis
- Severe Dehydration
- Suspected non-accidental trauma
- Unstable vital signs
- Profuse bleeding
- Any other condition considered to be critical by the base hospital
- Near-Drowning (non-traumatic mechanism)
- Minor Burns

Pediatric Burn Emergencies:

Major Burns are defined as Partial or Full Thickness burns covering more than 25% TBSA (10% in children under 10)

1. Transport major burns to a Level 1 Burn Center
2. Patients with airway compromise should be taken to the closest appropriate categorized general ED.

Special considerations should be made for the following situations. Contact medical control of further consultation is needed.

- Burns associated with inhalation injury or airway compromise.
- Full or partial thickness burns involving face, eyes, hands or feet, genitalia, perineum, suspected child abuse, and major burns.
- All high voltage electric burns, including lightening injury.

Pediatric Trauma Emergencies:

Pediatric trauma patients should be brought to an appropriately designated regional pediatric trauma center based on regional trauma triage guidelines.

Addendum: Definitions

Severe Respiratory Distress

1. Evidence of supraclavicular, sternal, or intercostal, retractions
2. Nasal flaring (<2 yr)
3. Grunting respirations
4. Tripod position
5. Stridor at rest
6. Marked Wheezing
7. Pulse oximetry < 95%

Altered Mental Status

1. Coma
2. Unexplained combativeness
3. Postictal states with no previous history of seizure, or lasting >10 minutes
4. GCS \leq 10

Severe dehydration

1. Change in vital signs
2. Capillary refill > 3 seconds (in normothermic patient)
3. Dry mucous membranes
4. Depressed fontanelle
5. Altered mental status
6. Decrease in urinary output
6. History of ongoing diarrhea
7. Vomiting losses for >48 hours

Signs of meningitis

1. Fever with nuchal rigidity
2. Altered mental status; vomiting; seizures
3. Petechial or purpuric rash below nipple line
4. Poor eye control (<2 yr)

Status epilepticus

1. Two or more generalized tonic-clonic seizures without complete recovery of full consciousness between seizures, or
2. Continuous tonic-clonic seizure activity for >15 minutes