Pediatric Trauma Care

Jennifer Wobig, RN, BSN
Trauma Program Manager
Santa Barbara Cottage Hospital

Cheryl Wraa, MSN, FAEN
Director, Trauma Care After Resuscitation Programs
Project Manager, TACTICAL Grant

Differences in mechanisms and patterns of injury result in the need for a unique response to pediatric trauma, and the need for specialized pediatric resources.

What is required
• Committed TMD and Trauma Team
  • Can be fulfilled by Adult trauma Surgeons

• Trauma Service trained and credentialed to provide pediatric trauma care
  • CME, training/education

• Regional trauma system to integrate Children’s Hospitals for the most critically injured patients
  • Referral pattern/transfer agreements for higher level of care if needed

Volume Requirements

Level 1 (admit 200 or more kids per year younger than the age of 15)

Level II (admit 100 or more kids per year younger than the age of 15)

Physician resources:

Board Certified Pediatric Surgeons
Level II PTC: Board Certified Specialists
Level I PTC: Fellowship trained

Specialists:
Orthopedics
Neurosurgery
Critical Care
Emergency Medicine

• Assume a leadership role within respective local, regional and state systems
  • Accept transfers from non-pediatric trauma centers
  • Participate in regional injury prevention
  • Participate in regional outreach/education

• Performance Improvement
  • Pediatric process and outcome measures
  • NTDB
  • Pediatric TQIP

What do we do for the small rural hospitals?

• Active collaboration with Pediatric Specialists:
  • Involvement with Pediatric Critical Care (co-management) or Pediatricians
  • Pediatric Trauma Service still maintains oversight while in the PICU
WASHINGTON (April 13, 2015) — Pediatric emergency care coordinators in the nation’s emergency departments are strongly linked with improved readiness to care for children, according to a new study in JAMA Pediatrics. Nearly 50 percent of the nation’s emergency departments have a physician or nurse dedicated to address staff training, equipment availability and policies for the care of children — a three-fold increase since 2003.

Areas for improvement:

Disaster Plans. Only 47 percent of respondents had a disaster plan that addresses issues specific to the care of children.

Equipment. At least 15 percent of emergency departments lacked one or more specific pieces of equipment as recommended by the 2009 guidelines, such as pediatric Magill forceps for removal of airway foreign bodies.

Guidelines Implementation. Nearly 81 percent of respondents reported barriers to guidelines implementation. The most frequent barriers reported were cost of training personnel (54 percent) and lack of educational resources (49 percent).

Marianne Gausche-Hill, MD, FACEP, FAAP, of the Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center

Thank You
Jennifer Wobig & Cheryl Wraa