Head Injury Pathway

Clinical Assessment/ Management tool for Children

Management - Acute Setting

Patient presents

Suspected/ Observed Head Injury?
Perform full PAWS including BP

History:

- When? Mechanism of injury?
- Loss of consciousness ? Vomiting? Fitting? Persisting dizziness?
- Amnesia (anterograde /retrograde)?
- Worsening headache?
- Clotting disorder?

Examination:

- Assess conscious level - GCS (see table 2) and pupils
- Confused or repetitive speech?
- Skull integrity (bruises; wounds; boggy swelling) + fontanelle assessment
- Signs of base of skull fracture
- Signs of focal neurology
- Cervical spine
- If under 3 years, undress and examine fully

Do the symptoms and/or signs suggest an immediately life threatening injury?

Yes

- **Inform EPIC/PEM Cons (Mon-Fri 13-20.30)**
- **Move to Resus**
- **Consider 2222**

Are there safeguarding concerns (e.g. delay in presentation; injury not consistent with history or age/ developmental stage of child)?

Concern

Contact EDT +/- Paediatric Safeguarding Consultant

NICE Head Injury Algorithms
(See Algorithm 2)

No Risk factors

Provide written and verbal discharge advice

If concussion, provide written and verbal advice about graded return to normal activities

No

Isolated Risk Factor

- Have **safeguarding** concerns been excluded
- Discuss with **Paeds/PEM Cons** if <1yr old
- Any visible mark in a non-mobile (not crawling) infant will need Paediatric Review
- Observe in department for 4 hours post-injury
- Provide analgesia

- **SDM** may consider Ondansetron if vomiting only risk factor

Any concerning features during observation?

Yes

>1 risk factor

- If only risk factor if >3 vomits since injury must be discussed with SDM
- Otherwise arrange CT head
- **If CT head normal but remains symptomatic discuss with Paediatrics**

Table 2: Modified Glasgow Coma Scale for infants and Children

	Child	Infant	Score
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain only	To pain only	2
	No response	No response	1
Best verbal response	Oriented, appropriate	Coos and babbles	5
	Confused	irritable cries	4
	Inappropriate words	Cries to pain	3
	Incomprehensible sounds	Moans to pain	2
	No response	No response	1
Best motor response*	Obey commands	Moves spontaneously and purposefully	6
	Localises painful stimulus	Withdraws to touch	5
	Withdraws in response to pain	Withdraws to response in pain	4
	Flexion in response to pain	Abnormal flexion posture to pain	3
	Extension in response to pain	Abnormal extension posture to pain	2
	No response	No response	1

* If patient is intubated, unconcious, or preverbal, the most important part of this scale is motor response. Motor response should be carefully evaluated.

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This guidance was written in collaboration with the SE Coast SCN and involved extensive consultation with healthcare professionals in Wessex . It has been edited by the CHT team to fit local processes.