

Management - Acute Setting

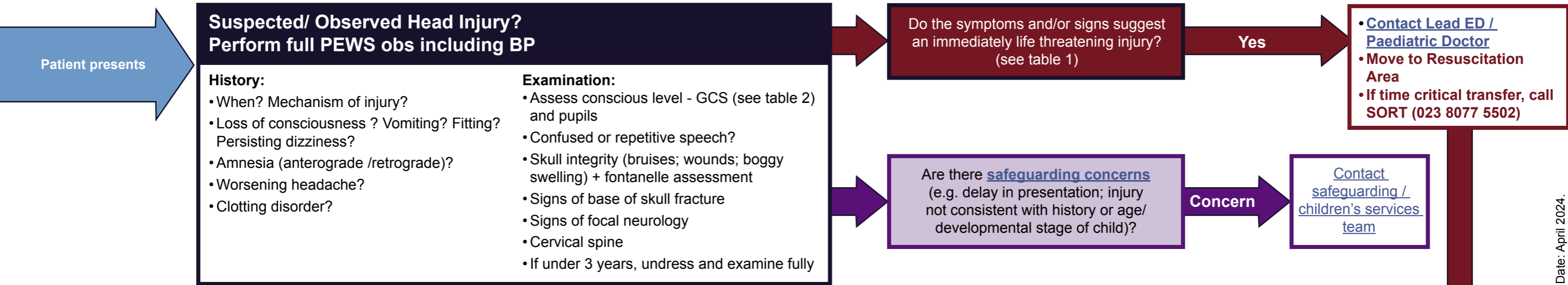
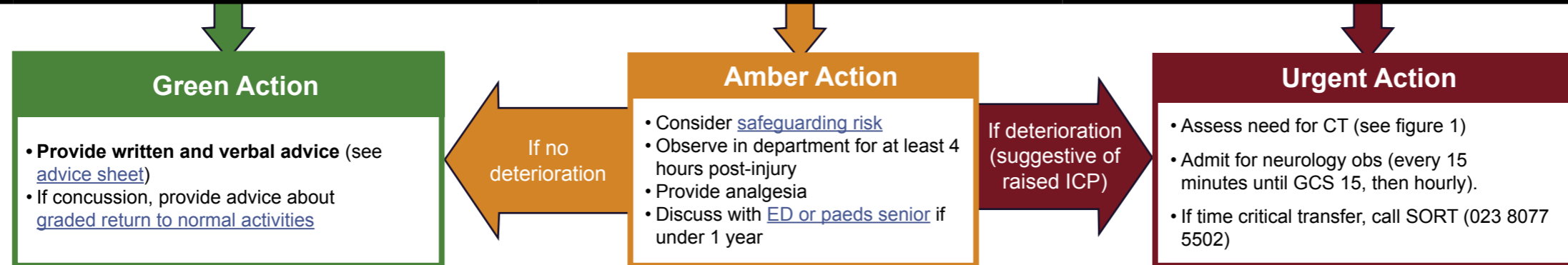


Table 1

	Green - low risk	Amber - intermediate risk	Red - high risk
Nature of injury and conscious level	<ul style="list-style-type: none"> Low risk mechanism of injury No loss of consciousness Child cried immediately after injury Alert, interacting with parent, easily rousable Behaviour considered normal by parent 	<ul style="list-style-type: none"> Mechanism of injury: fall from a height > 1m or greater than child's own height Alert but irritable and/or altered behaviour 	<ul style="list-style-type: none"> Mechanism of injury: considered dangerous (high speed road traffic accident; >3m fall) Suspicion of NAI GCS < 15 / altered level of consciousness Witnessed loss of consciousness lasting > 5mins Persisting abnormal drowsiness Post traumatic seizure
Symptoms & Signs	<ul style="list-style-type: none"> 2 or less episodes of vomiting Minor bruising or minor cuts to the head 	<ul style="list-style-type: none"> 3 or more discrete episodes of vomiting (>10 minutes apart) Persistent or worsening headache Amnesia or repetitive speech 	<ul style="list-style-type: none"> Skull fracture – open, closed or depressed Tense fontanelle (infants) Signs of basal skull fracture (haemotympanum, 'panda' eyes, CSF leakage from ears/ nose; Battle's sign (mastoid ecchymosis) Focal neurological deficit A bruise, swelling or laceration > 5cm if age < 1 year
Other		<ul style="list-style-type: none"> Clotting disorder Additional parent/carer support required 	



First Draft Version: June 2016 Date of this Refreshed Version: April 2021 Review Date: April 2024.

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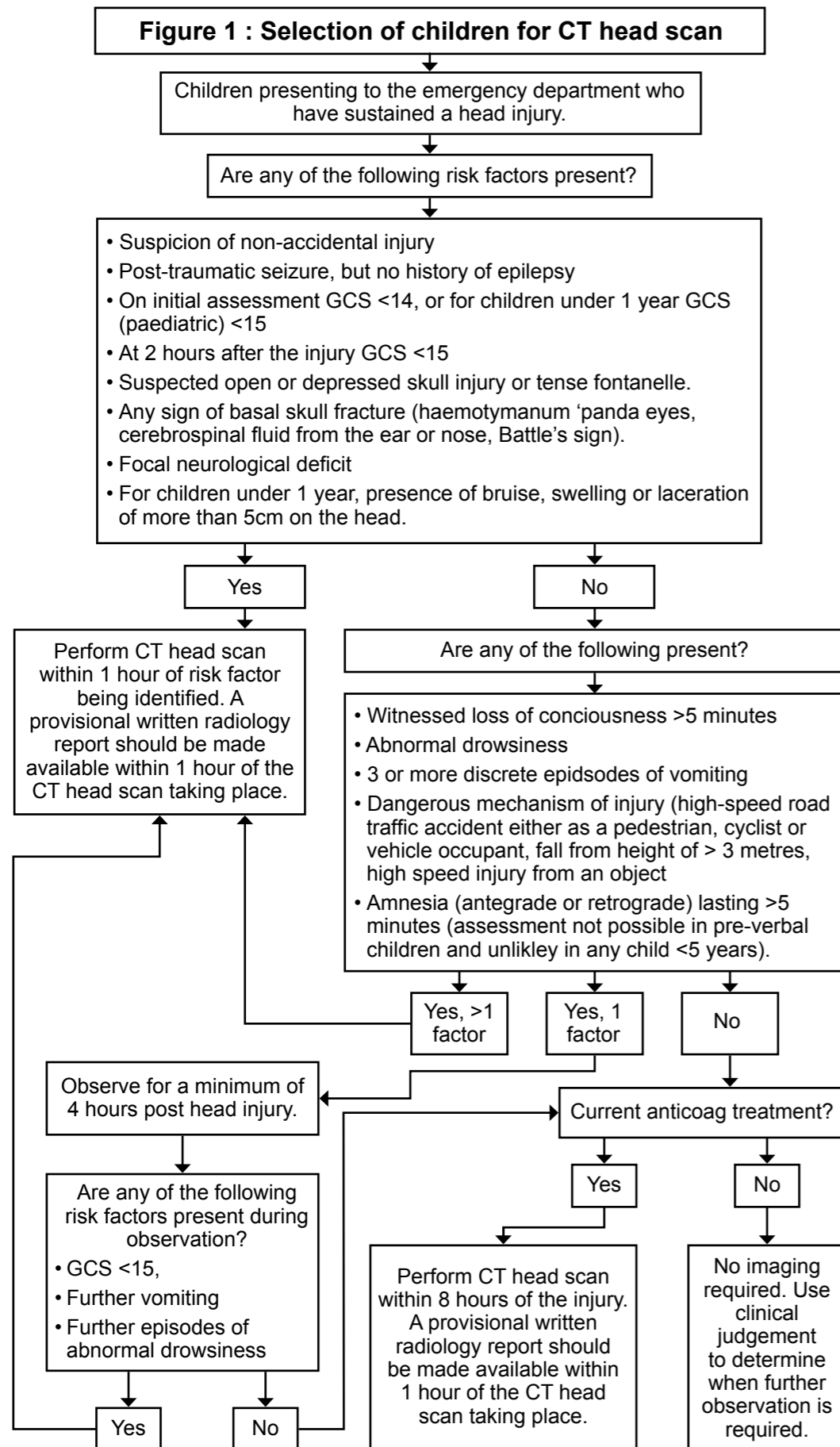


Table 2: Modified Glasgow Coma Scale for infants and Children

	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, unconscious, or preverbal, the most important part of this scale is motor response. Motor response should be carefully evaluated.