Head Injury Flowchart

Ondansetron should not be given to children with head injury without ED Consultant approval

Mild Head Injury

- AVPU = A
- GCS = 14-15
- No LOC
- Disorientation
- ≤ 1 vomit
- Normal neurology
- No physical evidence of skull fracture

- Observe for 2-4 hours post injury

Symptomatic

Yes

No

Discharge home with
Head Injury Health Fact Sheet

Moderate Head injury

- AVPU = AV
- Brief LOC
- Drowsy
- ≥ 2 vomits
- Normal neurology
- Brief seizure after head injury
- Large scalp bruise or laceration
- Amnesia of event

- Admit to ED Observation Ward
- Neurological observations hourly
- Refer to ED Guideline: **Criteria Led Discharge**
- Consider CT (see Head Injury Guideline

Severe Head Injury

- AVPU = PU
- LOC ≥ 5 mins
- Seizures
- Focal neurological deficit
- Penetrating head injury
- Signs of raised intracranial pressure

- To resuscitation room
- Assess and manage ABC
- Initiate c-spine precautions

- Intubate and ventilate to protect airway
- ETCO2 should be maintained at 35-45mmHg
- Hyperventilation should be reserved for children with signs of raised ICP
- Insert oro gastric tube
- Urgent CT scan
- PICU consult

Skull X-Rays

- Rarely required but should be considered in < 1 year olds who have a boggy or depressed area

Intracranial Pressure

- 3mL/kg IV of 3% saline slow push

OR

- 20% **Mannitol** 0.5-1g/kg (2.5-5mL/kg) IV over 20 minutes
- Insert urinary catheter
- Plus
- Head position should be kept midline and the bed elevated to 30° degrees

Anti Seizure Prophylaxis

- **Phenytoin** 20mg/kg over 20 minutes
- Seizures are common with severe traumatic brain injury. Particularly in the first 24 hours.