PAEDIATRIC RETRIEVAL TEAM
Pre-Transport Stabilisation

A – AIRWAY

- Intubate ideally with a cuffed/uncut ETT. Ensure ETT is secured with tape.
- Nurse patient with ETT in a downward position.

A POST INTUBATION CHEST X-RAY AND BLOOD GAS WOULD BE HELPFUL FOR TEAM TO VIEW ON ARRIVAL

B- BREATHING

- For correct suction catheter size double the diameter of ETT and round down if necessary – for example for size 3.5mm generally use size 6ch catheter.
- Ensure regular suction is carried out – particularly in patients with bronchiolitis/ respiratory tract infections, as these patients are particularly prone to increased secretions which may hinder ventilation.
- Avoid suctioning past the end of ETT as deep suctioning will result in trauma and damage to the airway.
- Ventilated children will require a nasogastric tube to be passed – usually during bag/mask ventilation or prior to intubation. This is predominantly to decompress abdomen to aid oxygenation/ventilation but also to empty stomach contents and reduce risk of aspiration. Generally a size 8ch for smaller infants and 10ch for older children would be suitable.
- If a gastrostomy tube is present them this should be placed on free-drainage.
- An orogastric tube should be passed on children with a head injury due to the risk of basal skull fracture.

IT WOULD BE HELPUL IF NG/OG IS PASSED PRIOR TO CHEST X-RAY TO CONFIRM POSITION

C- CIRCULATION

VASOACTIVE DRUGS

- Vasoactive drugs may be required where cardiovascular insufficiency persists despite resuscitation and should be considered in patients who have received >40mls/kg fluid resuscitation and remain hypotensive.
- Generally our first line inotrope is adrenaline.
- These can be infused via a large peripheral line with caution and close monitoring.
- Consideration should be made for central and arterial access when inotropes are introduced.
- Instructions for preparation can be found on the website on the drug calculator

Fluids IN

- Take into account any infusions already running and deduct these from fluid allowance.
- As a maintenance fluid we would use 0.9% Sodium chloride + 5% Glucose.
- Consider using 0.9% Sodium Chloride + 10% Glucose as a maintenance for neonates as they are prone to hypoglycaemia.
- For fluid boluses use balanced crystalliods – Plasmalyte or 0.9% Sodium Chloride

Fluids OUT

- Paralysed and sedated patients are at risk of urine retention and urinary catheterisation should be considered.
- Ideally older children (or those no longer in nappies) should be catheterised to prevent contamination of equipment etc.
- Cardiac patients, patients in shock and those receiving drugs affecting urine output – diuretics, mannitol etc., should also be catheterised to monitor urine output.

D- DISABILITY

Measure Glucose ASAP - If Blood Glucose is low < 3.5mmols/l then a bolus of 10% Glucose (2mls/kg) is required and then ensure a adequate level is maintained.

IF POSSIBLE PLEASE ENSURE A RECENT BLOOD GLUCOSE/BLOOD GAS PRIOR TO TEAM ARRIVING

E- EXPOSURE

- Aim to maintain normothermia (36.5-37.5oC).
- Babies in particular should be carefully monitored as they are at increased risk of hypothermia.
- Various methods can be used to warm including – TransWarmer, bair hugger, blankets/foil blankets, hats or head covering.
- If a child is pyrexial methods such as – anti-pyretic drugs, cool packs and fan and exposing skin should be used.

DRUGS

- Once intubated patients should remain sedated with Morphine and Midazolam infusions.
- A Rocuronium infusion or boluses are also usually required.

See website for instructions on preparing these infusions and usual dosing.

The drug calculator on the website will give correct drug dosing when the patients weight is entered – this can then be printed out and kept at patients bedside.

Please ensure all syringes and lines are clearly labelled.

GENERAL INFORMATION

PLEASE ENSURE ALL RELEVENT NOTES ARE PHOTOCOPIED FOR THE TEAM TO TAKE TO THE RECEIVING HOSPITAL

(Medical notes, nursing notes, drug kardex, observations)

PARENTS

- Usually ONE parent may travel with the team however space can be very limited and depending on the mode of transport and number of team members travelling it may not always be possible.
- When the referral is made the team will be able to inform you of any travel constraints – COVID Amber/red pathway or backup aircraft with limited capacity
- If the patient is being transferred by air we will need to know a recent weight for the travelling parent / guardian.
- During road transfers the travelling parent would generally be travelling backwards and therefore if there is a history of motion sickness this may need to be a consideration.
- If the parents are unable to accompany the patient and do not have their own transport we would kindly ask the referring hospital to arrange transport for the family.

TO REQUEST ScotSTAR ADVICE OR TO ARRANGE A RETRIEVAL PLEASE CALL:

03333 990222