**Serious injury update: essential information for instructors**

It is essential that all instructors read and fully assimilate the changes before teaching on the injury elements of the APLS, APLS recertification and PLS courses.

This update has been produced following the outcome of a national consensus meeting hosted by ALSG and attended by experts in the field of paediatric trauma management.

On the APLS course, it is recommended that the serious injury recognition and management lecture/interactive and the trauma stabilisation skill station/workshop are given by someone who has current knowledge and experience of children’s injury management. Instructors should take the opportunity to ‘sit in’ on the serious injury lecture/interactive to ensure that the key messages are delivered consistently in the other serious injury stations.

On the APLS recertification and PLS courses, it is recommended that at least one instructor with relevant experience is allocated to the trauma stations.

*Summary of the changes*

Cervical spine stabilisation

In-line with the new FPHC consensus guideline1 the approach to spinal immobilisation is a stepwise approach following the current algorithm (see Figure 13.5 in APLS manual). The method of stabilisation should be considered carefully:

* Manual in-line stabilisation (MILS)
* Blocks where necessary if suggested by mechanism of injury (see NIHCE guidance)
* There is no evidence of the benefit of using collars in children and in many cases they are contraindicated e.g. penetrating trauma and, therefore, their use will no longer be routinely taught on APLS, APLS recertification and PLS courses
* Spinal board used only for extrication with rapid transfer to a scoop stretcher for transportation and early removal from scoop stretcher in ED
* Minimal handling with 20o tilt is recommended (rather than log roll) as described in the FPHC consensus guidelines1

Haemorrhage control

* <C>ABC with assessment for catastrophic haemorrhage and immediate response to this before Airway assessment.
* Pelvic binders may be applied in the pre-hospital setting or ED for pelvic stabilisation and haemorrhage control. Remember ‘first clot, best clot’ principle and do not remove pelvic binder until cleared by someone with expertise in this area. Proprietary pelvic splints are available for children. However, there may need to be some innovative approaches to the equipment used depending on the size of the child and the equipment you have available. For example, an adult BP cuff may be more effective in an infant.

Approach to fluids

* First fluid bolus of 10ml/kg followed by reassessment
* Blood. If blood not available, then a further fluid bolus of 10ml/kg followed by reassessment
* Where indicated, implement massive haemorrhage protocol. Examples of massive transfusion policies can be viewed here <http://www.ukemtrauma.com/network-protocols.html>
* Early surgical consultation and intervention

***Impact on the course***

All of the trauma related materials have been updated:

* Serious injury chapter in APLS manual
* E-modules associated with serious injury
* Serious injury teaching and assessment materials
* MCQs

Prior to teaching on a course if you have any questions about this update please email them to [traumaupdate@alsg.org](mailto:traumaupdate@alsg.org)

If you have any comments during or at the end of the course, please feed these back to your course director who will be submitting immediate feedback to ALSG on behalf of the faculty.

Thank-you for your continued support

1 <http://www.fphc.co.uk/content/EducationEvents/ConsensusStatements.aspx>