# Advice for transferring head injured patients requiring urgent neurosurgery.

The transferring team should be lead by a doctor capable of dealing with problems related to endotracheal tube, including accidental extubation.

- secured oral endotracheal tube of appropriate size
- oro - gastric tube
- **<u>two</u>** secure points of intravenous access
- monitoring
    - ECG
    - oxygen saturation
    - **<u>end-tidal CO2</u>**
    - blood pressure – preferably arterial
    - temperature
- ventilate to normocapnia ( 4.5 -5 kPa) and maintain oxygen greater than 12 kPa. Use capnography and assess accuracy against arterial blood gases
- sedation, analgesia and muscle relaxation – Propofol infusion is contraindicated < 17yrs for sedating intensive care patients.
- normal maintenance fluids calculated by weight. For younger children this should contain dextrose and be isotonic. For the older child give normal saline
- urinary catheter
- ensure adequate circulating volume – restore deficit with crystalloid/colloid/blood
- exclude hypoglycaemia
- position 30 degrees head up
- full spinal immobilisation at all times
- splintage of fractures
- patient secured on trolley with appropriate restraints
- copies of patients notes and radiographs
- observations recorded every 15 minutes
- age appropriate equipment to provide on-going resuscitation and emergency care in-transit

- self-inflating bag and suction must always be available
- adequate supplies of oxygen and reserve for emergency use
- transfer for urgent neurosurgery will require use of lights and sirens but remember safety of the patient, team and other road users is paramount
- parents stay at the referring hospital until the team is ready to leave and they are advised not to follow the ambulance
- ring accepting unit to advice them of ETA and up to date condition
- mobile phone to allow access to advice en -route