

GETAC Pediatric Committee

Approved by GETAC Nov. 24, 2025

Consideration for Pediatric Consultation and Transfer

Introduction

13,000 severely injured children were transferred to higher levels of care and specialty services among trauma centers participating in the American College of Surgeons (ACS) Trauma Quality Programs in 2020.¹ The transport of a critically ill or injured child from one facility to another can be complex and stressful for the pediatric patient, the child's caregivers, and the health care team. Preplanned processes can ensure the transition of care is smooth, reduces the strain of complex events, and the pediatric patient remains safe during the transfer. Coordination between health care teams, at both ends of the transfer, and with the transport team ensures safe execution of interfacility transfer of pediatric patients.

Opportunities for communication breakdown, diagnosis discordance, and delays in care may occur during interfacility transfer of children. Handoffs during transitions of care are the leading cause of serious medical errors, and interfacility transfers increase risk with different hospitals involved.² Quality improvement strategies are key to addressing such events and implementing planned processes that can help prevent errors.

1. American College of Surgeons. (n.d.). Trauma quality programs participant use file. Retrieved from <https://www.facs.org/quality-programs/trauma/quality/national-trauma-data-bank/datasets>

2. Hamline, M. Y., & Rosenthal, J. L. (2020). Interfacility transfers: A process riddled with improvement opportunities. *Hospital Pediatrics*, 10(2), 195–197.

<https://doi.org/10.1542/hpeds.2019-0305>

Hospitals that are designated trauma centers in Texas must have transfer guidelines in place as part of the designation process. In response to the many requests for a template or guideline, the Pediatric Committee of the Governor's EMS and Trauma Advisory Council adopted this guideline that hospitals may utilize as their own transfer guideline.

The transfer guideline was developed in accordance with published standards (internet and print) across the nation at other trauma centers, a publication from the AAP (American Academy of Pediatrics), the Emergency Medical Services for Children Innovation and Improvement Center as well as published National Highway Traffic Safety Administration (NHTSA) standards regarding mode of transport. The transfer guideline is meant to be inclusive of pediatric critical illness as well as pediatric trauma.

This guideline is not part of the Texas Health and Safety Code or the Texas Administrative Code and is intended to serve as a template that facilities may adopt to fulfill requirements for trauma designation or simply to facilitate development of appropriate pediatric interfacility transfer guidelines.

The Department of State Health services does not mandate Texas State designated trauma centers or non-trauma center hospitals must use this guideline but offers it to assist trauma centers and non-trauma centers in the development of their own guideline. The Department recognizes the varying resources of different centers and, how what works for one hospital, may not be suitable for others. The decision to use this guideline in any situation always depends on the independent medical judgment of the medical provider.

Consideration for Pediatric Consultation and Transfer

Trauma and Critical Illness

The transfer of pediatric patients with traumatic injuries as well as non-traumatic illness is addressed in the following document. The State of Texas has adopted four levels of trauma

care to enhance the care of injured patients across the State. The acutely injured child who does not require critical care management can be cared for in a level 3 or level 4 Trauma Center. It is only the critically injured child and/or a child whose level of care needs exceed the local area capability who should be transferred to the most appropriate designated trauma facility with pediatric capabilities. It is accepted that some level 3 trauma patients may be admitted to an ICU for close observation; but if the patient begins to require critical care management, the patient should be transferred to the most appropriate designated trauma center with pediatric capabilities to care for a critically injured child. All ACS verified trauma centers must follow the standards for Pediatric Readiness. "Pediatric readiness" refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to an injured child³.

³. Resources for Optimal Care of the Injured Patient: 2022 Standards, American College of Surgeons Committee on Trauma, page 90

In addition, pediatric patients with a non-traumatic illness can also be cared for in regional facilities. However, patients should be transferred to a higher level of care when their medical and/or nursing care needs exceed what is available in their community.

Texas is such a vast geographically challenging state and Trauma Services Areas are well defined with existing referral patterns; it is not the intent of this guideline to change those already established relationships. However, it is intended to encourage hospitals to align themselves with a facility that has the capacity to manage pediatric critical care and pediatric trauma. It is not intended to mandate transfer outside a region but to heighten the awareness of the need for pediatric critical care and trauma services.

The following contains guidelines for when to transfer the critically injured and/or ill pediatric patient. The guideline serves as a resource for hospitals in the State of Texas. The Texas Governor's EMS and Trauma Advisory Council recognizes a pediatric patient as one under 15

years of age. It is noted that many pediatric patients in their early teens may be the size of a small adult which may prompt physicians and surgeons to keep them in their local facility. Much caution is advised with this practice, as these patients still have emotional and physical needs akin to all children such as child life services as well as nurses and ancillary staff, trained to care for the pediatric patient. Hospitals in Texas may have their own definition of a pediatric patient but typically a patient >17 years of age is considered an adult.

Consideration for Pediatric Trauma Transfer

Physiologic Criteria:

1. Depressed or deteriorating neurologic status (GCS \leq 12) with focus on changes in the motor function score or decreased AVPU.
2. Severe respiratory distress and/or respiratory failure
3. Children requiring airway and/or ventilatory support
4. Status post cardiopulmonary arrest
5. Shock, not responsive to 40mL/kg of fluid resuscitation
6. Children with indication of a need for any of the following:
 - a. Invasive monitoring (arterial, central venous or pulmonary artery pressure)
 - b. Intracranial pressure monitoring
 - c. Vasoactive medications and/or blood

Anatomic Criteria:

1. Penetrating wounds to the head, neck, thorax, abdomen or pelvis including the groin
2. Head injury when accompanied by any of the following:
 - a. Cerebrospinal fluid leak
 - b. Open head injuries (excluding simple scalp injuries)
 - c. Depressed skull fractures
 - d. Post-resuscitation decreased level of consciousness (GCS \leq 12) or decreased AVPU

- e. Intracranial hemorrhage
- 3. Spinal cord or column injuries
- 4. Significant blunt injury to the chest, abdomen or neck (e.g. hanging or clothesline MOI's)
- 5. Traumatic amputation of an extremity with potential for replantation
- 6. Fracture of two or more major long bones (such as femur, humerus)
- 7. Fractures and/or deep penetrating wounds to an extremity complicated by neurovascular compromise or compartment injury

Consideration for Pediatric Non-Trauma Transfer

Physiologic Criteria:

- 1. Depressed or deteriorating neurologic status (GCS \leq 12) or decreased AVPU
- 2. Severe respiratory distress and/or respiratory failure
- 3. Children requiring airway and/or ventilatory support.
- 4. Symptomatic cardiac rhythm disturbances (congenital vs. metabolic vs ingestion)
- 5. Status post cardiopulmonary arrest.
- 6. Evidence of new or worsening heart failure.
- 7. Shock not responding to 40mL/kg fluid resuscitation.
- 8. Children with indication for any one of the following.
 - a. Arterial pressure monitoring.
 - b. Central venous pressure or pulmonary artery monitoring.
 - c. Intracranial pressure monitoring.
 - d. Vasoactive medications.
 - e. Treatment for severe hypothermia or hyperthermia
 - f. Treatment of any end-organ failure.
 - g. Treatment for renal failure, acute or chronic requiring immediate dialysis.

Other Criteria for trauma or non-trauma transfer:

1. Submersion injury with hypoxemia or any history of loss of consciousness or unstable vital signs
2. Status epilepticus
3. Potentially dangerous envenomation. Use of a snakebite protocol is encouraged as well as contact with poison control
4. Potentially life-threatening ingestion of, or exposure to, a toxic substance,
5. Severe Electrolyte Imbalance.
6. Severe metabolic disturbances
7. Severe Dehydration
8. Potentially life-threatening infections, including sepsis,
9. Child found down for no apparent reason,
- 10 Any condition that exceeds the capability of the facility

Indications of Inflicted Injury (Child Abuse):

Red Flags and Management excerpted from the Child Physical Abuse Screening/Management Toolkit from the GETAC Pediatric Committee.

Access at [Child Physical Abuse \(CPA\) Screening/Management Toolkit](#)

“Red Flag” History of Present Injury:

1. No history or inconsistent history
2. Changing history
3. Unwitnessed injury
4. Unexplained delay in seeking care
5. Prior ED visit

6. Domestic violence in the home
7. Premature infant (<37 wks.)
8. Low birth weight/IUGR
9. Chronic medical conditions
10. Referred for suspected inflicted injury/child abuse

“Red Flag” Physical Exam Findings:

1. Torn oral frenulum
2. Failure to thrive (weight, length, head circumference)
3. Large head in infant (consider measuring of OFC in children <1yr.)
4. Any bruise in any non-ambulating child- “if you don’t cruise, you don’t bruise”
5. Any bruise in a non-exploratory location [especially the TEN region – Torso (area covered by the standard girl’s bathing suit), Ears and Neck] < 4 yrs. Old (TEN-4)
6. Bruises, marks, or scars in patterns that suggest hitting with an object
7. Perineal bruising or injury

“Red Flag” Radiographic Findings

1. Metaphyseal fractures (corner)
2. Rib fractures (especially posterior) in infants
3. Any fracture in a non-ambulating infant
4. An undiagnosed healing fracture
5. Subdural and/or subarachnoid hemorrhage on neuroimaging in young children, particularly in the absence of skull fractures in a <1 yr. old child

Complete revised-ESCAPE Screening Tool-Consider Positive if 1 “yes” Answer.

Recommended evaluation in cases of suspected physical abuse with positive screening.
NOTE: May require transfer for complete workup for Inflicted Injury.

Pediatric patients with burn injuries should be transferred to a Burn Center

American Burn Association Transfer Criteria:

Patients with burn injuries should be transferred to a burn center based on the latest recommendation from the ABA. A burn center may treat adults, children, or both.

See appendix 1 for specific recommendations for burns requiring transfer to a burn center.

Consideration for Interfacility Transport:

Method of Transport and Team Configuration

Decision to Transfer: The decision to transfer a patient is based on the previously listed anatomic and/or physiologic criteria in which the care of the patient is above and beyond the capability of the sending facility. Sending facilities need to have established guidelines/processes regarding the initiation of the transfer (i.e. who talks to whom), gathering the required paperwork, as well as the process of informing the family and giving them directions to the accepting facility.

Method of Transport: The method of interfacility transport is dependent on many variables. Texas encompasses a large geographic area that will impact travel time during transfers. Additionally, established TSA's have very different methods of transport as well as levels of care available specific to a region.

Transport by private vehicle is not recommended for critically ill or injured children. Two things to consider when transferring patients are the appropriate mode of transport and the capability of the transport personnel.

Special consideration should be given for international transports. Intercept transports should be avoided.

Definition: For the purposes of this document, a pediatric transport team is considered a specialty care transport team. The Texas Administrative Code Title 25, Part I, Chapter 157 Subchapter B, Rule §157.11 defines a Specialty Care Transport as follows:

A Specialty Care Transport is defined as the interfacility transfer by a department licensed EMS provider of a critically ill or injured patient requiring specialized interventions, monitoring and/or staffing.

Specialty Transport Teams

To qualify to function as a Specialty Care Transport the following minimum criteria shall be met:

(1) Qualifying Interventions:

a. patients with one or more of the following IV infusions: vasopressors; vasoactive compounds; antiarrhythmics; fibrinolytics; tocolytics; blood or blood products and/or any other parenteral pharmaceutical unique to the patient's special health care needs; and

b. one or more of the following special monitors or procedures. mechanical ventilation; multiple monitors, cardiac balloon pump; external cardiac support (ventricular assist devices, etc.); any other specialized device, vehicle or procedure unique to the patient's health care needs.

2. Equipment. All specialized equipment and supplies appropriate to the required interventions shall be available at the time of the transport.

3. Minimum Required Staffing. One currently certified EMT-Basic and one currently certified or licensed paramedic with the additional training as defined in paragraph four (4) of this subsection; or, a currently certified EMT-Basic and a currently certified or licensed paramedic accompanied by at least one of the following: a Registered Nurse with special knowledge of the patient's care needs; a certified Respiratory Therapist; a licensed physician; or, any licensed health care professional designated by the sending physician.

4. Additional required training for certified/licensed paramedics: Evidence of successful completion of post-paramedic training and appropriate periodic skills verification in management of patients on ventilators, 12 lead EKG and/or other critical care monitoring devices, drug infusion pumps, and cardiac and/or other critical care medications, or any other specialized procedures or devices determined at the discretion of the provider's medical director.

If available, a specialty transport team should be used to transport critically ill or injured children.

Choosing the appropriate Transport Team

Equipment: (i.e. ALS, MICU, and/or specialty team) can be challenging given our state's rural nature as well as geographic obstacles. The following is a synopsis of what type of patient

can/should be transferred according to their level of care. At all times, the sending institution should be knowledgeable about the transport mode's pediatric capabilities, especially regarding pediatric equipment on board. If they do not have a specific item on board (example: pediatric nebulizer) the sending institution must ensure the patient leaves their facility with the needed piece of equipment.

Communication:

1. Both the sending and accepting facilities should have policies regarding hospital-to-hospital communication regarding:

1. Work-up required or not required prior to transport (i.e. CT scan)
2. Helping the sending facility determine mode/method of transport (i.e. air vs ground)
3. Patient stabilization requirements for transport.
4. Communication back to the accepting facility in regard to:
 - Patient arrival at the accepting facility with updated patient health status
 - Overall patient outcome
 - The ability to discuss any patient care specifics enabling both facilities to optimize patient care for future transfers.

Back-transfer:

The sending facility should be prepared for those patients requiring long-term or chronic care post injury/illness. Back-transfer is encouraged if the sending facility has the capability/capacity to care for the pediatric patient in the inpatient setting.

The Method of Transport:

The method of transport should be based on the patient's medical needs, the expedience of transport necessary for the patient, ground vs air, and the capability of the staff available on the chosen mode of transport. Each region should have specific processes to guide the use of transport assets for the region served. However, there are circumstances when taking an ALS unit out of a community, for example, renders the community without an advanced life support unit for a prolonged period. Therefore, in this situation, use of air medical transport may be required.

The following guidelines will help the provider determine which type of transport method to utilize when transferring a critically ill or injured child. This can also be divided into categories when assessing the method of transfer (ground vs air) as well as crew composition. (Per NHTSA April 2006 guidelines https://www.ems.gov/assets/Interfacility_Transfers.pdf) Additional NHTSA resources specific to helicopter (https://www.ems.gov/assets/guidelines_for_helicopter_emergency_Medical_transport.pdf) and ground transport of children in ambulances (<https://static.nhtsa.gov/nhtsa/downloads/p2017-documents/811677.pdf>) may be useful.

1. The availability of critical care and/or specialty care transport teams within reasonable proximity.
2. The modes of transportation and/or transport personnel available as options in the geographic area.
3. Specific circumstances associated with the specific transport situation (e.g. inclement weather, major media event, etc.)
4. Anticipated response time of the most appropriate team and/or personnel.
5. Established state, local, and individual transfer service standards and/or requirements.
6. Combined level of expertise and specific duties/responsibilities of the individual transporting team members.
7. Degree of supervision required by and available to the transport team members.
8. Complexity of the patient's condition.
9. Anticipated degree of progression of the patient's illness/injury prior to and during transport.
10. Technology and/or special equipment to be used during transport.
11. Scope-of-practice of the various team members

Transport Team Configuration: Patient factors

The sending facility needs to determine the risk for deterioration of the pediatric patient to determine the crew composition and ultimately, the method of transport. According to the National Highway Traffic Safety Administration (NHTSA) guidelines from April 2006, the following categories for risk are utilized. The desired team configuration is based on the NHTSA guidelines and adapted for pediatrics:

Stable with no risk for deterioration

Basic Life Support:

Oxygen, monitoring of vital signs, saline lock at the discretion of medical control

Stable with low/medium risk of deterioration

Advanced Life Support or MICU as defined by Texas Administrative Code, Rule §157.11 with consideration for use of Pediatric Transport Team based on the patient's underlying medical condition and reason for transfer:

Running IV, some IV medications including pain medications, pulse oximetry, increased need for assessment and interpretation skills, 3-lead EKG monitoring, basic cardiac medications, e.g., heparin or nitroglycerine

Stable with high risk for deterioration or Unstable

Use of Pediatric Transport Team highly encouraged when available in the following patient situations:

1. Advanced airway management required; secured airways, intubated, on ventilator
2. Multiple vasoactive medication drips,
3. Condition has been initially stabilized, but has likelihood of deterioration, based on assessment or knowledge of provider regarding specific illness/injury,
4. Cannot be stabilized at the transferring facility,
5. Condition deteriorating or likely to deteriorate, such as patients who require invasive monitoring, balloon pump,
6. Post-resuscitation, or who have sustained multisystem trauma.

Strong consideration for air medical transport or critical care ground transport is recommended when the pediatric transport team is unavailable.

Mental Health

Between 2007 and 2016, ED visits to treat instances of deliberate self-harm increased by more than 300%, with further increase observed during the COVID-19 pandemic. Hospital admission

rates for adult and pediatric patients with mental health conditions have increased concurrently.

³⁶ The growing prevalence of mental health conditions, in tandem with a national shortage of mental health professionals, has contributed to an increasing number of youth presenting to hospitals with mental health crises. (McCarty 2022) Many of these children require interfacility transfer for definitive care. The decision to transfer a child with a mental health emergency is based on the patient's objective clinical needs and the available resources. (Kissee 2021) The logistics of interfacility transfer include challenges associated with determining bed availability, getting insurance approvals, and arranging transportation. (McCarty 2022)

McCarty, E. J., Nagarajan, M. K., Halloran, S. R., Brady, R. E., House, S. A., & Leyenaar, J. K. (2022). Healthcare quality during pediatric mental health boarding: A qualitative analysis. *Journal of Hospital Medicine*, 17(10), 783–792. <https://doi.org/10.1002/jhm.12906>

Kissee, J. L., Huang, Y., Dayal, P., Yellowlees, P., Sigal, I., & Marcin, J. P. (2021). Association between insurance and the transfer of children with mental health emergencies. *Pediatric Emergency Care*, 37(12), e1026–e1032.

<https://doi.org/10.1097/PEC.0000000000001881>**Pediatric Interfacility Transfer Quality Improvement Program**

Pediatric patients requiring interfacility transfer present unique challenges that necessitate careful planning, coordination, and monitoring to ensure their safety and well-being. The **Pediatric Interfacility Transfer Quality Improvement (QI) Program** is designed to standardize and enhance the quality of care for these patients. This guideline provides a framework for healthcare organizations to implement and sustain a robust QI program for pediatric transfers, with an emphasis on safety, efficiency, and improved clinical outcomes.

Introduction and Program Goals

The primary goal of the Pediatric Interfacility Transfer QI Program is to improve the transfer process for pediatric patients, ensuring that they receive appropriate and timely care during transport between healthcare facilities. By standardizing protocols, involving stakeholders, and focusing on continuous improvement, healthcare organizations can ensure that pediatric transfers are handled with the highest level of professionalism and care. The program's objectives include enhancing patient safety, improving operational efficiency, and optimizing clinical outcomes.¹

Stakeholder Engagement

Successful pediatric interfacility transfers require the collaboration of a diverse range of stakeholders. The program involves healthcare teams such as pediatricians, emergency medicine physicians, emergency department nurses, EMS personnel, transport specialists, and administrators. Each team member plays a critical role in ensuring a seamless transfer process, from the initial decision to transfer through the patient's arrival at the receiving facility.

Engagement with regulatory bodies and adherence to established guidelines are key components of the program. Facilities should align their practices with national standards, such as those established by the Joint Policy Statement: "Pediatric Readiness in Emergency Department"² and state-specific guidelines like the "Considerations for Pediatric Consultation and Transfer" document.³ Additionally, families play an essential role in the transfer process. By incorporating family feedback through post-transfer surveys and focus groups, facilities can better understand the patient and family experience, ensuring that their concerns and needs are addressed.⁴

Assessment of Current Practices

Before implementing improvements, healthcare organizations must assess their current pediatric transfer practices. A thorough assessment begins with the collection of data in key areas, such as transfer times, patient stabilization, clinical outcomes, and protocol adherence.⁵ Facilities should conduct a gap analysis to identify discrepancies between current practices and best-practice standards outlined by the AAP and other professional organizations.²

Benchmarking is a valuable tool in this process. By comparing performance metrics with state and national standards, facilities can identify areas where they may be lagging and set specific, measurable goals for improvement.⁶

Establishing Quality Metrics

To monitor and improve the quality of pediatric transfers, facilities must establish clear quality metrics that are tracked over time. These metrics fall into two categories: **process metrics** and **outcome metrics**.

- **Process metrics** measure the effectiveness and efficiency of the transfer process. Key metrics include the time from transfer request to the initiation of transport, adherence to

clinical protocols, and the effectiveness of communication between the sending and receiving facilities.⁶

- **Outcome metrics** focus on the clinical outcomes of the transferred patients. These metrics include mortality and morbidity rates, successful stabilization of the patient prior to transfer, and family satisfaction with the transfer process.⁷

By tracking these metrics, healthcare organizations can continuously assess their performance and identify opportunities for improvement.⁶

Development of Protocols and Guidelines

Standardization of the transfer process is critical to ensuring consistent, safe care for pediatric patients. Healthcare organizations should develop or update their Standard Operating Procedures (SOPs) for pediatric interfacility transfers, ensuring alignment with national guidelines and other established best practices.²

Additionally, the creation of clinical pathways for common conditions requiring transfer, such as respiratory distress, trauma, or sepsis, helps ensure that all healthcare providers follow a consistent approach to care. These pathways should be detailed and provide step-by-step instructions on the management of pediatric patients during transfer.¹

Interfacility transfer agreements should also be standardized to ensure clear expectations between sending and receiving facilities. These agreements should outline each facility's responsibilities, including communication protocols, patient handoff processes, and documentation requirements.⁵

Training and Education

The success of a Pediatric Interfacility Transfer QI Program hinges on the education and training of staff involved in the transfer process. Regular training sessions should be offered to ensure all staff members are proficient in pediatric transfer protocols and best practices. Simulation-based training and scenario-based exercises are highly effective tools for preparing healthcare teams for real-world pediatric transfer scenarios.²

In addition to initial training, ongoing competency assessments are necessary to ensure staff maintain their skills and knowledge. Continuing education opportunities should also be made available, providing staff with the latest updates in pediatric care and transfer management.⁷

Implementation Plan

To ensure the successful rollout of the Pediatric Interfacility Transfer QI Program, healthcare organizations should adopt a structured implementation plan. A phased approach allows for careful monitoring and adjustment throughout the process.

Begin with a pilot phase, where the program is tested in a controlled environment, such as a single department or within a specific patient population.¹ Feedback from this pilot phase will inform necessary refinements to protocols and procedures. Once the pilot phase is complete, a phased rollout can occur, extending the program across the facility or healthcare system.¹

The use of change management strategies is essential during the implementation phase. Engaging staff and leadership, providing clear communication about the program's goals, and fostering a collaborative environment will increase the likelihood of a successful transition.¹

Continuous Monitoring and Feedback

The QI program's long-term success depends on continuous monitoring and adaptation. Healthcare organizations should establish systems for real-time data monitoring, allowing them to track key metrics and identify areas of concern immediately.⁶

Creating structured feedback loops with staff, patients, and families ensures that the program evolves based on real-world experiences. Regular feedback from frontline healthcare providers and families involved in the transfer process can identify bottlenecks or gaps in care that may not be apparent from data alone.⁴

Additionally, regular audits of the program's processes will ensure ongoing adherence to established protocols. These audits should focus on both process and outcome metrics, identifying areas for improvement and ensuring that high standards of care are maintained.⁷

Reporting and Communication

Transparency is a core component of the Pediatric Interfacility Transfer QI Program. Internal reporting mechanisms should be established to track progress and communicate key performance indicators (KPIs) to clinical leadership, quality improvement teams, and other stakeholders.⁶

Externally, organizations should report relevant data to regulatory bodies such as state health departments, ensuring compliance with state and federal requirements.⁷ Patient and family communication is equally important. Healthcare organizations should openly share information

about the QI program with patients and families, helping to build trust and confidence in the transfer process.⁴

Annual Review and Program Evolution

The QI program is designed to evolve based on data, feedback, and emerging best practices. Each year, facilities should conduct a formal annual review of the program, assessing its performance against established metrics and identifying areas where adjustments are needed.⁵

This review process should be data-driven and focused on continuous improvement, ensuring that the program remains responsive to the needs of pediatric patients, families, and healthcare providers. Regular updates to protocols and training programs will keep the QI program aligned with the latest evidence-based practices.²

Conclusion

The Pediatric Interfacility Transfer Quality Improvement Program provides a comprehensive framework for ensuring the safety, efficiency, and effectiveness of pediatric transfers. By focusing on stakeholder collaboration, evidence-based protocols, staff training, and continuous monitoring, healthcare organizations can significantly improve outcomes for pediatric patients requiring transfer between facilities.¹

References

1. Institute for Healthcare Improvement (IHI). "How to Improve: Model for Improvement" Institute for Healthcare Improvement, 2019. Available at: <https://www.ihl.org/resources/how-improve-model-improvement>
2. Remick K, Gausche-Hill M, Joseph MM, et al; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine and Section on Surgery, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee. Pediatric Readiness in the Emergency Department. *Pediatrics*. 2018;142(5):e20182459
3. Governor's EMS and Trauma Advisory Council Pediatrics Committee. "Consideration for Pediatric Consultation and Transfer." Available at: <https://files.constantcontact.com/a2806160801/b202ed7b-3d86-4c2f-a4de-650d75ad1b00.pdf>
4. Family Voices. "Tips for Title V Programs: Partnering with Families. Family Voices, 2016. Available at: <https://familyvoices.org/resource/tips-for-title-v-programs-partnering-with-families-2/>

5. Agency for Healthcare Research and Quality (AHRQ). "Pediatric Quality Indicator Measures" AHRQ Quality Indicators, 2024. Available at: [https://qualityindicators.ahrq.gov/measures/pdi_resources#:~:text=The%20Pediatric%20Quality%20Indicators%20\(PDIs,characteristics%20of%20the%20pediatric%20population.](https://qualityindicators.ahrq.gov/measures/pdi_resources#:~:text=The%20Pediatric%20Quality%20Indicators%20(PDIs,characteristics%20of%20the%20pediatric%20population.)
6. National EMS Quality Alliance (NEMSQA). "National EMS Quality Alliance Measure Set." Available at: <https://www.nemsqa.org/nemsqa-measures>
7. Joint Commission. Joint Commission Accreditation Standards. Available at: <https://www.jointcommission.org/standards/>

Appendix 1 attached ABA One-Page Guideline for Burn Patient Referral

Guidelines for Burn Patient Referral



(Advice on Transfer and Consultation)

- These guidelines are designed to be used to aid in clinical decision making. If you have sustained a burn injury, please seek medical advice from a medical professional.
- Local and regional infrastructure, resources, and relationships may determine the necessity and timeliness of burn center referral.
- These guidelines are not meant to be definitive care recommendations. They may facilitate building the proper referral network within the local healthcare community.

	Immediate Consultation with Consideration for Transfer	Consultation Recommendation
Thermal Burns	<ul style="list-style-type: none"> • Full thickness burns • Partial thickness $\geq 10\%$ TBSA* • Any deep partial or full thickness burns involving the face, hands, genitalia, feet, perineum, or over any joints • Patients with burns and other comorbidities • Patients with concomitant traumatic injuries • Poorly controlled pain 	<ul style="list-style-type: none"> • Partial thickness burns $< 10\%$ TBSA* • All potentially deep burns of any size
Inhalation Injury	<ul style="list-style-type: none"> • All patients with suspected inhalation injury 	<ul style="list-style-type: none"> • Patients with signs of potential inhalation such as facial flash burns, singed facial hairs, or smoke exposure
Pediatrics (≤ 14 years, or < 30 kg)	<ul style="list-style-type: none"> • All pediatric burns may benefit from burn center referral due to pain, dressing change needs, rehabilitation, patient/caregiver needs, or non-accidental trauma 	
Chemical Injuries	<ul style="list-style-type: none"> • All chemical injuries 	
Electrical Injuries	<ul style="list-style-type: none"> • All high voltage ($\geq 1,000V$) electrical injuries • Lightning injury 	<ul style="list-style-type: none"> • Low voltage ($< 1,000V$) electrical injuries should receive consultation and consideration for follow-up in a burn center to screen for delayed symptom onset and vision problems

Burn Severity Determination

SUPERFICIAL

- Dry, red, easily blanching, sometimes painful
- Example: Sunburn
- NOT counted in calculations of total burn surface area (TBSA)

SUPERFICIAL PARTIAL THICKNESS

- Moist, red, blanching, blisters, very painful
- Counted in calculations of total burn surface area (TBSA)

DEEP PARTIAL THICKNESS

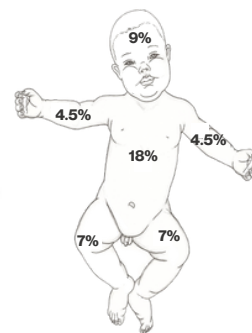
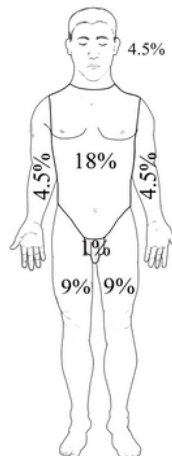
- Drier, more pale, less blanching, less pain
- Counted in calculations of total burn surface area (TBSA)

FULL THICKNESS

- Dry, leathery texture, variable color (white, brown, black), loss of pin prick sensation
- Counted in calculations of total burn surface area (TBSA)

*Percentage Total Body Surface Area (TBSA)

"RULE OF NINES"



"PALMAR METHOD"



Patient's entire palmar surface is approximately 1%

For more information visit ameriburn.org/burnreferral

<https://academic.oup.com/jbcr/advance-article-abstract/doi/10.1093/jbcr/iraa038/5775361?redirectedFrom=fulltext>

Copyright© 2022 American Burn Association. The downloadable PDF of the ABA Guidelines for Burn Patient Referral may be distributed in its original form, in its entirety, without permission provided that attribution is given to the American Burn Association. All requests to edit, repurpose, or reprint require permission by emailing abacentraloffice@ameriburn.org with the details of the request.