An understanding of the ability of ambulance personnel, general practitioners, and parents to recognise a seriously ill child may be relevant to prioritising responses for children.

In a retrospective study of the three months from 1 October to 31 December 1995, 9412 children (0-14 years) were taken to the Paediatric Accident and Emergency (PAE) Department at Queen’s Medical Centre, Nottingham. Of 1036 general practitioner referrals, 546 (52.7%) required admission, five of these (0.9%) were referred to the paediatric intensive care unit (PICU). Of the 8376 self referrals, 840 (10%) required admission, 30 of them (3.6%) of the admissions to the PICU.

None of the five general practitioner referrals requiring paediatric intensive care were admitted to the resuscitation room. They were taken to the routine PAE area, two by “non-999” ambulance and two by parents using their own transport. The notes of the fifth child were unavailable. The ambulance report forms were unavailable.

Twenty of the 840 self-referral patients admitted to the PICU were brought by “999” ambulance to the resuscitation room. Of the remaining 10 patients taken to the routine PAE area, five arrived by “999” ambulance and five arrived by other means of transport. All 10 children had potentially life threatening conditions, including septicaemia, meningitis, upper airway obstruction, hypovolaemia, and coma. Ambulance report forms were available for two of those arriving by “999” ambulance.

During the three month period a further 40 patients were taken to the resuscitation area by “999” ambulance; three died, 34 were admitted to medical, surgical, or orthopaedic wards, and three were discharged home. Two of the three children discharged home had burns which proved to be less than 5%, and the remaining child recovered from the effects of alcohol ingestion.

The recognition of a seriously ill child demands exceptional expertise. Our small sample suggests that parents, general practitioners, and “999” ambulance personnel may all fail to recognise the seriously ill child.

If prioritisation of ambulance response is to benefit sick children, those questions asked of parents and general practitioners who request an ambulance must reflect the difficulties encountered in recognising a seriously ill child. Equally, recognising the seriously ill child’s condition should be fundamental to the training of paramedics and ambulance technicians.

A very small number of seriously ill children will continue to be brought to accident and emergency departments by other means than the ambulance service. It is vital that such children are received by nursing and medical staff skilled in assessing their needs and responding accordingly.

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Abstract—Prioritisation of ambulance response is the subject of ongoing debate and evaluation. An understanding of the ability of ambulance personnel, general practitioners, and parents to recognise a seriously ill child may be relevant to prioritising responses for children.

In a retrospective study of the three months from 1 October to 31 December 1995, 9412 children (0-14 years) were taken to the Paediatric Accident and Emergency (PAE) Department at Queen’s Medical Centre, Nottingham. Of 1036 general practitioner referrals, 546 (52.7%) required admission, five of these (0.9%) were referred to the paediatric intensive care unit (PICU). Of the 8376 self referrals, 840 (10%) required admission, 30 of them (3.6%) of the admissions to the PICU. None of the five general practitioner referrals requiring paediatric intensive care were admitted to the resuscitation room. They were taken to the routine PAE area, two by “non-999” ambulance and two by parents using their own transport. The notes of the fifth child were unavailable. The ambulance report forms were unavailable.

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