NEONATAL AND PEDIATRIC PATIENT ASSESSMENT

SOUTH COOK COUNTY EMS SYSTEM

OCTOBER 2024 CE

0704-78-E-1224

OBJECTIVES

- IDENTIFY THE RISK FACTORS ASSOCIATED WITH THE NEED FOR NEONATAL RESUSCITATION.
- DESCRIBE THE PHYSIOLOGICAL ADAPTATIONS AT BIRTH.
- OUTLINE THE PREHOSPITAL ASSESSMENT AND MANAGEMENT OF THE NEONATE.
- DESCRIBE RESUSCITATION OF THE DISTRESSED NEONATE.
- DISCUSS POST-RESUSCITATIVE MANAGEMENT AND TRANSPORT.
- DESCRIBE SIGNS AND SYMPTOMS AND PREHOSPITAL MANAGEMENT OF SPECIFIC NEONATAL RESUSCITATION SITUATIONS.

OBJECTIVES

- IDENTIFY INJURIES ASSOCIATED WITH BIRTH.
- DESCRIBE APPROPRIATE INTERVENTIONS TO MANAGE THE EMOTIONAL NEEDS OF THE NEONATE'S FAMILY.

DEFINITIONS

- ANTEPARTUM – THE PERIOD BEFORE LABOR AND DELIVERY.
- APNEA – AN ABSENCE OF SPONTANEOUS RESPIRATIONS.
- CONGENITAL ANOMALIES – DEFECTS THAT OCCUR DURING FETAL DEVELOPMENT.
- INTRAPARTUM – THE PERIOD DURING LABOR AND DELIVERY.
- MECONIUM STAINING – THE INHALATION OF MECONIUM BY THE FETUS OR NEWBORN; THIS CAN BLOCK AIR PASSAGES AND RESULT IN FAILURE OF THE LUNGS TO EXPAND OR CAUSE OTHER PULMONARY DYSFUNCTION.

DEFINITIONS

- NEONATE – IN INFANT IN THE FIRST 28 DAYS OF LIFE.
- NEWBORN – AN INFANT IN THE FIRST FEW HOURS OF LIFE.
- PRETERM INFANT – AN INFANT BORN BEFORE 37 WEEKS OF GESTATION.

RISK FACTORS

ANTEPARTUM

- MULTIPLE GESTATION
- INADEQUATE PRENATAL CARE
- MOTHERS AGE (<16 AND >35)
- HISTORY OF PERINATAL MORBIDITY OR MORTALITY.
- POST TERM GESTATION
- DRUGS/MEDICATIONS
- TOXEMIA, HYPERTENSION, DIABETES

INTRAPARTUM

- PREMATURE LABOR
- MECONIUM STAINED AMNIOTIC FLUID
- RUPTURE OF MEMBRANE >24 HOURS
- USE OF NARCOTICS WITHIN 4 HOURS OF DELIVERY
- ABNORMAL PRESENTATION
- PROLAPSED CORD
- BLEEDING
- PROLONGED LABOR OR PRECIPITOUS DELIVERY

NEONATAL RESUSCITATION EQUIPMENT AND MEDICATIONS

- IN ADDITION TO A STANDARD OB KIT, NEONATAL RESUSCITATION EQUIPMENT SHOULD INCLUDE THE FOLLOWING:
  - ET TUBE STYLETS
  - ET TUBE SIZES 2.5,3.0,3.5, AND 4.0
  - MECONIUM ASPIRATOR ATTACHMENT X3
  - LARYNGOSCOPE HANDLE AND BLADES MILLER SIZE 0 AND 1
  - INFANT OXYGEN MASKS
  - MULTIPLE BLANKETS

NEONATAL RESUSCITATION EQUIPMENT AND MEDICATIONS

- IN ADDITION TO A STANDARD OB KIT, NEONATAL RESUSCITATION EQUIPMENT SHOULD INCLUDE THE FOLLOWING:
  - MEDICATIONS AND FLUIDS
    - DEXTROSE 12.5%
    - EPINEPHRINE 1MG/10ML
    - NALOXONE
    - SODIUM BICARBONATE (INFANT 4.2% SOLUTION)
  - INFANT BVM
  - SUCTION CATHETERS (5, 8, AND 10 FRENCH)
  - SYRINGES (1, 3, 10, AND 20ML)

PHYSIOLOGICAL ADAPTATIONS AT BIRTH

- AT BIRTH, NEWBORNS MAKE 3 MAJOR ADAPTATIONS NECESSARY FOR SURVIVAL:
  - EMPTYING FLUIDS FROM THEIR LUNGS AND BEGINNING VENTILATION
  - CHANGES TO THEIR CIRCULATORY PATTERN
  - MAINTAINING BODY TEMPERATURE

PREVENTING HEAT LOSS AND AVOID HYPOTHERMIA

- IMMEDIATELY AFTER BIRTH THE INFANTS BODY AND HEAD SHOULD BE DRIED TO PREVENT EVAPORATIVE HEAT LOSS AND METABOLIC ISSUES THAT MAY BE BROUGHT ON BY COLD STRESS.
- THE ACT OF DRYING WILL ALSO PROVIDE GENTLE STIMULATION, WHICH MAY INITIATE RESPIRATIONS.
- COVER THE INFANTS HEAD AND WRAP THE BODY WITH A DRY BLANKET/TOWEL. THE MAJORITY OF HEAT LOSS CAN BE PREVENTED BY COVERING THE HEAD (20%)

MAINTAIN AN OPEN AIRWAY

- AFTER THE NEWBORN HAS BEEN DRIED AND COVERED THE NEXT STEP IS TO MAINTAIN AN OPEN AIRWAY.
- THIS IS DONE BY CORRECT POSITIONING AND SUCTION OF THE AIRWAY.
  - THE INFANT SHOULD BE PLACED ON THEIR BACK OR SIDE WITH THE HEAD IN A NEUTRAL POSITION. CARE SHOULD BE TAKEN TO PREVENT HYPER/UNDER EXTENSION WHICH MAY COMPROMISE THE AIRWAY.
  - WHEN SUCTIONING, MOUTH THEN NOSE, THIS WILL AID IN AVOIDING ASPIRATION.

EVALUATE THE INFANT

- APGAR SCORES ENABLE A RAPID ASSESSMENT OF THE INFANT AT 1 AND 5 MINUTES OF LIFE.
- 7-10 NORMAL
- 4-6 MODERATELY DISTRESSED
- <4 SEVERELY DISTRESSED

Apgar Scoring System

Indicator		0 Points	1 Point	2 Points
A	Activity (muscle tone)	Absent	Flexed arms and legs	Active
P	Pulse	Absent	Below 100 bpm	Over 100 bpm
G	Grimace (reflex irritability)	Floppy	Minimal response to stimulation	Prompt response to stimulation
A	Appearance (skin color)	Blue; pale	Pink body, Blue extremities	Pink
R	Respiration	Absent	Slow and irregular	Vigorous cry

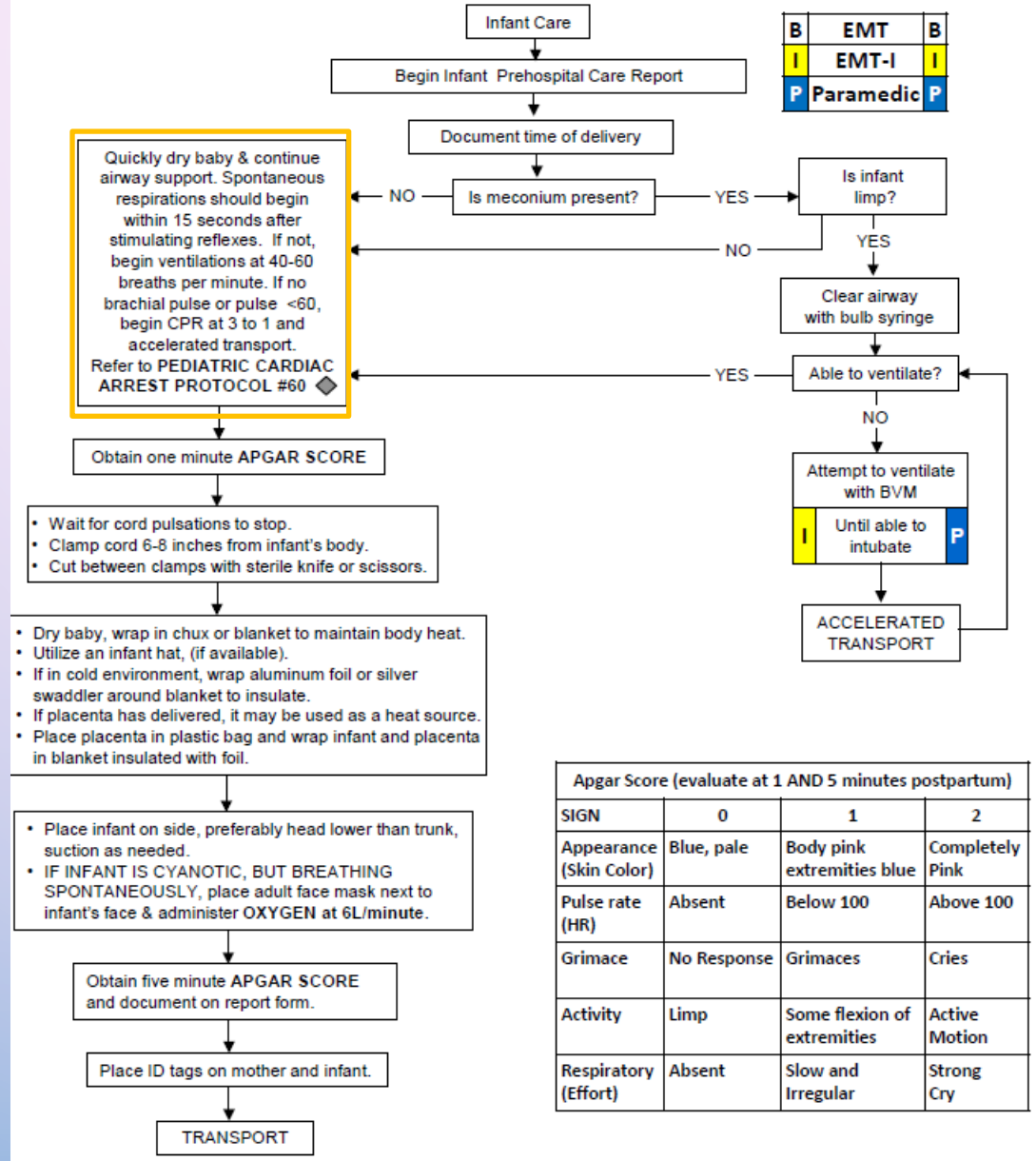
RESUSCITATION AND CARE OF THE NEWBORN

- FOR RESUSCITATION AND CARE REFER TO REGION 7 PROTOCOL 56
- FOR CARDIAC ARREST REFER TO REGION 7 PROTOCOL 60
- A REMINDER….. IN AN INFANT, IF THE PULSE IS ABSENT OR BRACHIAL PULSE <60. CPR IS TO BE ADMINISTERED AT A 3:1 RATIO AND ACCELERATED TRANSPORT.

OB / GYNE

Protocol 56

RESUSCITATION AND CARE OF THE NEWBORN



Apgar Score (evaluate at 1 AND 5 minutes postpartum)			
SIGN	0	1	2
Appearance (Skin Color)	Blue, pale	Body pink extremities blue	Completely Pink
Pulse rate (HR)	Absent	Below 100	Above 100
Grimace	No Response	Grimaces	Cries
Activity	Limp	Some flexion of extremities	Active Motion
Respiratory (Effort)	Absent	Slow and Irregular	Strong Cry

Revised: 05/01/16

Effective: 05/01/98

PEDIATRIC

Revised: 05/01
Effective: 05/01

Protocol 60

PEDIATRIC CARDIAC ARREST

- Establish unresponsiveness
- Position airway
- Determine breathlessness
- Ventilate with BVM 100% OXYGEN
- Determine pulselessness
- Initiate compressions, and continue as indicated
- Maintain airway
- (BLS) AED (if available), (ILS/ALS) Quick look/cardiac monitor

B	EMT	B
I	EMT-I	I
P	Paramedic	P

Ventricular Fibrillation or Pulseless Ventricular Tachycardia

I **Defibrillate at 2 J/kg** P
Resume CPR immediately

Give 5 cycles of CPR (15:2)
During CPR Secure airway and confirm placement
I **Establish IV/IO NS at TKO** P

Continue CPR
I **Defibrillate at 4 J/kg**
Resume CPR immediately
EPINEPHRINE (0.1mg/ml) at 0.01mg/kg
IV/IO (0.1ml/kg) Repeat every 3-5 minutes P

I **Defibrillate at 4 J/kg** P
Resume CPR immediately
Give 5 cycles of CPR (15:2)

I **LIDOCAINE at 1mg/kg IV/IO** Repeat every 3-5 minutes. Max total dose 3mg/kg P

Pulseless Electrical Activity (PEA) or Asystole

Resume CPR immediately
During CPR Secure airway and confirm placement
I **Establish IV/IO NS at TKO** P

I **EPINEPHRINE (0.1mg/ml) at 0.01mg/kg**
IV/IO (0.1ml/kg) Repeat every 3-5 minutes P

Identify and treat possible causes:

Hypovolemia	**20ml /kg IV fluid bolus**
Hypoxia	Ventilate w/100% **OXYGEN** (Check tube placement)
Acidosis/Hypoxemia	Ventilate w/100% **OXYGEN** (Check tube placement)
Hypothermia	Follow appropriate protocol
Hypoglycemia	Follow appropriate protocol
Hypo/Hyperkalemia	**20ml /kg IV fluid bolus**
Toxins	**20ml /kg IV fluid bolus**
Tamponade,cardiac	**20ml /kg IV fluid bolus**
Tension Pneumo	Pleural Decompression
Thrombosis/PE	Rapid TRANSPORT w/100% **OXYGEN**
Trauma	Follow appropriate protocol

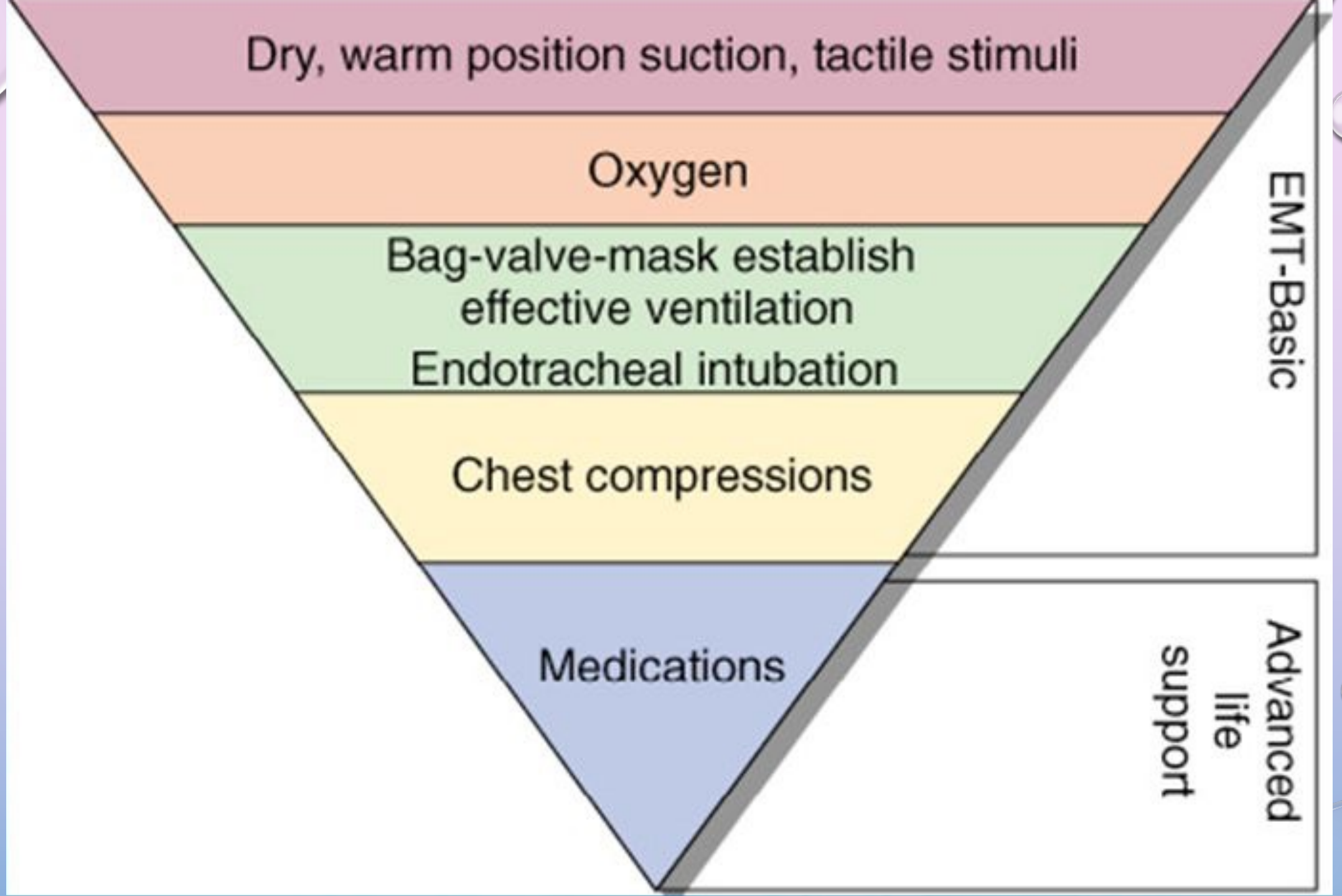
I **Fluid bolus at 20ml/kg**, may repeat as indicated. Max 60ml/kg P
**D25% at 2ml/kg IV/IO
**D12.5% at 4ml/kg IV/IO infants <2months
NARCAN at 0.1mg/kg IV/IO/IM/IN. Max single dose 2mg

P **BICARB 8.4%* at 1meq/kg IV/IO OR 1ml/kg** P
*BICARB 4.2% at 1meq/kg IV/IO OR 2ml/kg infants <3 months

Support CABs
Complete initial assessment
Observe
Keep warm
RAPID TRANSPORT

P **NOTE TO PREHOSPITAL PROVIDERS**: P
1. Acidosis in children is primarily a problem of ventilation and oxygenation.
2. **BICARBONATE** administration should be reserved for unobserved arrests or prolonged resuscitations ≥10 minutes
* To make **BICARBONATE 4.2%** dilute **BICARBONATE 8.4%** 1:1 with sterile water or normal saline

I ** 1. To make **D25%** dilute **D50%** 1:1 with sterile water or normal saline I
2. To make **D12.5%** dilute **D25%** 1:1 with sterile water or normal saline
3. To make **D12.5%** from **D50%** follow steps 1 & 2


Dry, warm position suction, tactile stimuli
Oxygen
Bag-valve-mask establish effective ventilation
Endotracheal intubation
Chest compressions
Medications
EMT-Basic
Advanced life support

PEDIATRICS

- CHILDREN HAVE UNIQUE ANATOMICAL, PHYSIOLOGICAL, AND PSYCHOLOGICAL CHARACTERISTICS THAT CHANGE DURING DEVLOPMENT. THE FOLLOWING IS A REVIEW AND APPROACH STRATEGIES BY AGE GROUP.

GROWTH AND DEVELOPMENT

- INFANT (2 – 12 MONTHS)
- MAJOR FEAR
  - SEPARATION AND STRANGERS
- APPROACH STRATEGIES
  - MINIMIZE SEPARATION FROM PARENTS

GROWTH AND DEVELOPMENT

- TODDLERS (1 – 3 YEARS)
- MAJOR FEAR
  - SEPARATION AND LOSS OF CONTROL
- APPROACH STRATEGIES
  - KEEP EXPLANATIONS SIMPLE, CHOOSE WORDS CAREFULLY, LET TODDLER PLAY WITH EQUIPMENT (STETHOSCOPE), AND MINIMIZE SEPARATION FROM PARENTS.

GROWTH AND DEVELOPMENT

- PRESCHOOLER (3 – 5 YEARS)
- MAJOR FEAR
  - BODILY INJURY, LOSS OF CONTROL, THE UNKNOWN AND DARK, BEING LEFT ALONE
- APPROACH STRATEGIES
  - BE HONEST, KEEP EXPLANATIONS SIMPLE AND CONCISE, CHOOSE WORDS CAREFULLY, EMPHASIZE THAT PROCEDURE WILL HELP THE CHILD BECOME HEALTHIER.

GROWTH AND DEVELOPMENT

- SCHOOL AGE (6 – 12 YEARS)
- MAJOR FEARS
  - LOSS OF CONTROL, BODILY INJURY, FAILURE TO LIVE UP TO EXPECTATIONS, DEATH
- APPROACH STRATEGIES
  - ASK THEM TO EXPLAIN WHAT THEY UNDERSTOOD, PROVIDE AS MANY CHOICES AS POSSIBLE, REASSURE THEM THAT THEY HAVE DONE NOTHING WRONG AND PROCEDURE ISN'T A PUNISHMENT, ANTICIPATE AND ANSWER ANY QUESTIONS

GROWTH AND DEVELOPMENT

- ADOLESCENT (13 – 18 YEARS)
- MAJOR FEAR
  - LOSS OF CONTROL, ALTERED BODY IMAGE, SEPARATION FROM PEER GROUP
- APPROACH STRATEGIES
  - WHEN APPROPRIATE ALLOW ADOLESCENT TO BE A PART IN DECISION MAKING, GIVE INFORMATION SENSITIVELY, USE OR TEACH COPING MECHANISMS SUCH AS RELAXATION, DEEP BREATHING, AND SELF COMFORTING TALK.

Ages	Heart Rate	Respiratory Rate	Systolic Blood Pressure	Temperature
Infancy (Birth to 1 Year)	100 to 160 (first 30 minutes) Settling around 120 bpm	40 to 60 initially 30-40 after first few minutes. 20-30 by one year	70 at Birth to 90 at 1 year	98-100
Toddler (12 to 36 Months) and Preschool Age (3 to 5 Years)	80 to 130 bpm 80 to 120 bpm	20 to 30 20 to 30	70 to 100 mmHg 80 to 110 mmHg	96.8 – 99.6
School-Age Children (6 to 12 Years)	70 to 110 bpm	20 to 30	80 to 120 mmHg	98.6
Adolescence (13 to 18 Years)	55 to 105 bpm	12 to 20	100 to 120 mmHg	98.6

ANATOMY AND PHYSIOLOGY REVIEW

- HEAD
  - A CHILD'S HEAD IS PROPORTIONALLY LARGE, IT ACCOUNTS FOR 25% OF THE TOTAL BODY WEIGHT.
  - DUE TO AN INCREASED SIZE IN THE OCCIPITAL REGION, PADDING MAY BE USED UNDER THE SHOULDERS TO MAINTAIN A NEUTRAL POSITION OF THE SPINE.
  - TO ACCOMMODATE FOR BRAIN GROWTH THE ANTERIOR FONTANELLE REMAINS OPEN FOR 9-18 MONTHS.
    - A TIGHT OR BULGING FONTANELLE INDICATES INCREASED INTRACRANIAL PRESSURE WHILE A SUNKEN FONTANELLE INDICATES POSSIBLE DEHYDRATION.

ANATOMY AND PHYSIOLOGY REVIEW

- AIRWAY
  - IN CHILDREN, STRUCTURES OF THE AIRWAY ARE NARROWER AND LESS STABLE. THIS CAN CAUSE THE AIRWAYS IN CHILDREN TO BECOME BLOCKED MORE EASILY BY SECRETIONS, OBSTRUCTIONS, AND INJURY/INFLAMMATION.
  - A SMALLER JAW AND LARGER TONGUE INCREASES THE CHANCE OF THE TONGUE OBSTRUCTING THE AIRWAY IN AN UNCONSCIOUS CHILD.
  - INTUBATION PRACTICES NEED TO BE MODIFIED TO ACCOMMODATE THE SOFT TISSUE OF THE AIRWAY THAT IS EASILY INJURED AND INFLAMED. USING A MILLER BLADE APPROPRIATE FOR THE AGE AND AN UNCUFFED ET TUBE IN CHILDREN <8 YEARS OF AGE.

ANATOMY AND PHYSIOLOGY REVIEW

- CHEST AND LUNGS
  - THE CHIEF SUPPORT OF THE CHEST WALL IN CHILDREN IS PRIMARILY MUSCLE RATHER THAN BONES. THE MUSCLES ARE IMMATURE AND CAN FATIGUE EASILY. THE CHEST WALL OFFERS LESS PROTECTION AND CHILDREN ARE SUCCEPTIBLE TO INJURY.
  - THE LUNG TISSUE IS FRAGILE, COUPLE THIS WITH THE LIMITED PROTECTION OF THE CHEST WALL, YOUNG CHILDREN CAN DEVELOP PULMONARY CONTUSIONS AND PNEUMOTHORAX FROM TRAUMATIC INJURY AT A HIGHER RATE.
  - THE MEDIASTINUM MAY HAVE A GREATER SHIFT WITH TENSION PNEUMOTHORAX AND A THIN CHEST WALL EASILY TRANSMITS LUNG SOUNDS WHICH MAY COMPLICATE ASSESSMENT OF PNEUMOTHORAX AND ET TUBE PLACEMENT.

ANATOMY AND PHYSIOLOGY REVIEW

- ABDOMEN
  - LIKE THE CHEST, THE IMMATURE MUSCLES IN THE ABDOMEN OFFER LITTLE PROTECTION. IN ADDITION, THE INTERNAL ORGANS ARE CLOSER TOGETHER. THE LIVER AND SPLEEN ARE PROPORTIONALLY LARGER AND MORE VASCULAR, AS WELL. THESE FEATURES ALLOW FOR MULTIPLE ORGAN INJURIES ASSOCIATED WITH ABDOMINAL TRAUMA.
  - THE LIVER AND SPLEEN ARE INJURED MORE OFTEN THAN IN AN ADULT PATIENT.

ANATOMY AND PHYSIOLOGY REVIEW

- EXTREMITIES
  - DUE TO THE SOFT COMPOSITION OF BONES IN A PEDIATRIC PATIENT, ALL SPRAINS AND STRAINS SHOULD BE TREATED AS FRACTURES AND MANAGED WITH FULL IMMOBILIZATION OF THE EXTREMITY.
  - PARAMEDICS SHOULD BE WARY OF INJURIES TO THE GROWTH PLATE THAT MAY DISRUPT BONE GROWTH.
  - CAREFUL IO TECHNIQUE IS CRITICAL BECAUSE IMPROPER INSERTION INTO THE GROWTH PLATE CAN AFFECT FUTURE BONE GROWTH.

ANATOMY AND PHYSIOLOGY REVIEW

- CARDIOVASCULAR SYSTEM
  - CARDIAC OUTPUT IS RATE DEPENDENT IN INFANTS AND SMALL CHILDREN (THE FASTER THE RATE, THE GREATER THE CARDIAC OUTPUT).
  - LOSS OF SMALL VOLUMES OF BLOOD CAN LEAD TO SHOCK.
  - A CHILD MAY BE IN SHOCK DESPITE A NORMAL BLOOD PRESSURE.
  - BRADYCARDIA IS OFTEN A RESPONSE TO HYPOXIA.

PEDIATRIC ASSESSMENT

- INITIAL ASSESSMENT
  - BEGINS WITH THE PARAMEDIC FORMING A GENERAL IMPRESSION OF THE PATIENT. THIS ASSESSMENT SHOULD FOCUS ON THE DETAILS MOST VALUABLE FOR DETERMINING WHETHER LIFE THREATENING CONDITIONS EXIST.
  - USING THE PEDIATRIC ASSESSMENT TRIANGLE:
    - HAS 3 COMPONENTS
      - APPEARANCE (MENTAL STATUS AND MUSCLE TONE)
      - WORK OF BREATHING (RESPIRATORY RATE AND EFFORT)
      - CIRCULATION (SKIN SIGNS AND SKIN COLOR)

PEDIATRIC ASSESSMENT

- INITIAL ASSESSMENT
  - AVPU SCALE
    - ALERT
    - VERBAL
    - PAINFUL
    - UNRESPONSIVE
  - PEDIATRIC GLASGOW COMA SCALE
    - THESE CAN BE USED TO DETERMINE THE CHILD'S LEVEL OF CONSCIOUSNESS.

PEDIATRIC GLASGOW COMA SCALE (PGCS)				
	> 1 Year		**< 1 Year**	**Score**
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	**2-5 Years**	**0-23 months**	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE (3-15):				

PEDIATRIC ASSESSMENT

- INITIAL ASSESSMENT
  - AIRWAY AND BREATHING
    - THE CHILD'S AIRWAY SHOULD BE PATENT, AND BREATHING SHOULD PROCEED WITH ADEQUATE CHEST RISE AND FALL. SIGNS OF RESPIRATORY DISTRESS INCLUDE THE FOLLOWING:
      - ABNORMAL BREATH SOUNDS, BRADYPNEA, GRUNTING, HEAD BOBBING, IRREGULAR BREATHING PATTERN, NASAL FLARING, TACHYPNEA, USE OF ACCESSORY MUSCLES.

PEDIATRIC ASSESSMENT

- CIRCULATION
  - THE PARAMEDIC ASSESSES CIRCULATION BY COMPARING THE STRENGTH AND QUALITY OF PERIPHERAL PULSES, MEASURING BLOOD PRESSURE (IN CHILDREN >3 YEARS), EVALUATING SKIN COLOR, TEMPERATURE, MOISTURE, TURGOR, AND CAPILLARY REFILL (<2 SECONDS IS NORMAL)

PEDIATRIC ASSESSMENT

- FOCUSED HISTORY
  - CHIEF COMPLAINT
    - NATURE OF ILLNESS OR INJURY
    - LENGTH (DURATION) OF ILLNESS/INJURY
    - LAST MEAL
    - PRESENCE OF FEVER
    - VOMITING OR DIARRHEA
    - FREQUENCY OF URINATION
  - MEDICATIONS AND ALLERGIES
  - MEDICAL HISTORY
    - PHYSICIAN CARE
    - CHRONIC ILLNESS

PEDIATRIC ASSESSMENT

- DETAILED PHYSICAL EXAM
  - THE PARAMEDIC SHOULD PERFORM A DETAILED PHYSICAL EXAM. THE EXAM SHOULD PROCEED HEAD TO TOE IN OLDER CHILDREN AND TOE TO HEAD IN CHILDREN <2 YEARS OLD.
  - IF TIME ALLOWS AND PATIENTS CONDITION WARRANTS, NONINVASIVE MONITORING OF PULSE OXIMETRY, BLOOD PRESSURE, AND MEASUREMENT OF BODY TEMPERATURE SHOULD BE ASSESSED.

PEDIATRIC ASSESSMENT

- DETAILED PHYSICAL EXAM
  - PUPILS – ARE THEY NORMAL/EQUAL IN SIZE AND DO THEY REACT TO LIGHT
  - CAPILLARY REFILL – MOST ACCURATE IN PATIENTS UNDER 6. IS IT LESS THAN 2 SECONDS (NORMAL) OR DELAYED?
  - HYDRATION – DOES THE SKIN SHOW NORMAL RESILIENCY (SKIN TURGOR)? ARE THERE TEARS AND SALIVA? ARE THE FONTANELLES IN THE INFANT SUNKEN OR FLAT?

PEDIATRIC ASSESSMENT

- ONGOING ASSESSMENT
  - APPROPRIATE FOR ALL PEDIATRIC PATIENTS AND SHOULD BE PERFORMED THROUGHOUT PATIENT CARE.
  - A KEY POINT TO REMEMBER IS THAT A PEDIATRIC PATIENTS CONDITION CAN CHANGE RAPIDLY.
  - VITAL SIGNS SHOULD BE ASSESSED:
    - EVERY 15 MINUTES IN A NON CRITICAL PATIENT
    - EVERY 5 MINUTES IN A CRITICAL PATIENT