

**PEORIA AREA EMS SYSTEM
PEDIATRIC PREHOSPITAL CARE MANUAL**

**Pediatric Assessment Process
and Management**

A patient **under the age of sixteen (16)** is considered to be a pediatric patient. Utilization of pediatric treatment guidelines and the extent of care rendered is based on the general impression of the pediatric patient's condition, physical examination findings and the history of the event. *Patients 16 years or older will be treated with adult protocols.*

The goal of the pediatric patient assessment process is similar to that of the adult patient. However, children are not "little adults". The causes of catastrophic events, such as cardiac arrest, are most often related to respiratory failure, shock or central nervous system injuries. Early recognition and treatment of the pediatric patient's injuries or illness is important to ensure the best outcome.

Special attention and awareness must be given to the pediatric patient's exceptional ability to compensate for respiratory failure and shock. Vital signs are valuable in the assessment of the pediatric patient but do have significant limitations and be dangerously misleading. For example, hypotension is a late and often sudden sign of cardiovascular decompensation. Tachycardia (which varies by age group) will persist until cardiac reserve is depleted. Bradycardia is an ominous sign of impending cardiac arrest.

Infants and children are able to maintain their blood pressure by increasing peripheral vascular resistance (shunting) and heart rate. **The pediatric patient can be in compensated shock and exhibit a normal blood pressure and skin condition.** This increases the importance of the EMS provider's understanding of pediatric vital signs and behavior patterns.

The EMS provider must establish a general impression of the pediatric patient. This impression, which is critical, should be done from the doorway of the room. Therefore, the pediatric patient will not be disturbed by a "hands-on" assessment. A simple question to ask yourself is, "How sick is this child?"

Three (3) key areas of importance of a general impression are:

- 1. Appearance**
- 2. Work of breathing**
- 3. Circulation to skin**

The three components are known as the *Pediatric Assessment Triangle (PAT)* established by the American Academy of Pediatrics (2000).

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Pediatric Assessment Triangle (PAT)

Appearance

The appearance of the pediatric patient should be assessed from the doorway. This is the most important aspect to consider when determining how sick or injured the child is. *Appearance* will give the EMS provider insight on oxygenation, neurological status and ventilation. Remember, the sick child may be alert on the conventional AVPU scale, but still have an abnormal appearance. Children need a more subtle assessment tool so that life-threatening injuries can be identified earlier. A good mnemonic to remember when assessing appearance is “tickles” (TICLS):

Characteristic	Features to look for:
Tone	Is he/she moving or resisting examination vigorously? Does he/she have good muscle tone? Or, is he/she limp, listless or flaccid?
Interactiveness	How alert is the child? How readily does a person, object, or sound distract him/her or draw his/her attention? Will he/she reach for, grasp and play with a toy or exam instrument such as a penlight or tongue blade? Or, is he/she uninterested in playing or interacting with the caregiver or prehospital professional?
Consolability	Can he/she be consoled or comforted by the caregiver or by the prehospital professional? Or, is his/her crying or agitation unrelieved by gentle assurance?
Look/Gaze	Does he/she fix his/her gaze on a face? Or, is there a “nobody home,” glassy-eyed stare?
Speech/Cry	Is his/her cry strong and spontaneous, or weak or high-pitched? Is the content of speech age-appropriate, or confused or garbled?

The *TICLS* Mnemonic (PEPP/AAP 2nd Edition 2006)

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Work of Breathing

Assessing work of breathing must go beyond the rate and quality of respirations that is used for adult patients. Work of breathing is an accurate indicator of the oxygenation and ventilation status of the pediatric patient. This is another “hands off” evaluation method in order to avoid disturbing the pediatric patient and causing anymore respiratory distress (other than what is already present).

Characteristic	Features to look for:
Abnormal Airway Sounds	Snoring, muffled or hoarse speech; stridor; grunting; wheezing
Abnormal Positioning	Sniffing position, tripodding, refusing to lie down
Retractions	Supraclavicular, intercostal, or substernal retractions of the chest wall; “head bobbing” in infants
Flaring	Flaring of the nares on inspiration

Characteristics of Work of Breathing (PEPP/AAP 2nd Edition 2006)

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Circulation to Skin

A rapid circulatory assessment is needed to determine the perfusion status of the pediatric patient. The key is to assess the core perfusion status of the child. Assessing the skin and mucous membranes can do this. Circulation to the skin reflects the overall status of core circulation.

Characteristic	Features to look for:
Pallor	White or pale skin/mucous membrane coloration from inadequate blood flow
Mottling	Patchy skin discoloration due to vasoconstriction/vasodilation
Cyanosis	Bluish discoloration of skin and mucous membranes

Characteristics of Circulation to Skin (PEPP/AAP 2nd Edition 2006)

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Pediatric Assessment Triangle (PAT)

Putting it all Together

The goal of pediatric patient care is to identify patients in shock or at risk of shock, initiating care that will directly assist maintaining the patient’s perfusion and safely transporting the patient to an emergency department or trauma center in a timely manner. The benefit of remaining on scene to establish specific treatments versus prompt transport to a definitive care facility should be a consideration of each patient contact. Requesting advanced assistance is another important resource that BLS & ILS providers should consider.

Notes on Pediatric Shock:

Mechanism	Medical	Traumatic
Hypovolemia	Blood Loss – Internal Bleeding Fluid Loss – Dehydration	Blood Loss – Trauma Fluid Loss – Burns
Cardiogenic (Pump Failure)	Respiratory Failure Airway Obstruction Dysrhythmia	Chest Trauma Pneumothorax Pericardial Tamponade
Vessel Failure	Sepsis Anaphylaxis Chemical/Poisoning Endocrine Dysfunction	Spinal Cord Injury (Neurogenic)

Peoria Area EMS System *Notes on Pediatric Shock*

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Pediatric Age Definitions & Assessment Considerations

Neonate (0-1 Month):

- Utilization of APGAR Scoring is helpful in assessing the neonate patient.

Infant (1-12 Months):

- Approach the infant slowly and calmly. Fast motion and loud noises may startle or agitate the infant.
- Use warm hands and assessment tools.
- Avoid doing anything potentially painful or distressing until after the assessment is completed.
- Have the caregiver assist in care – this is less threatening to the infant.
- Children over six (6) months of age are usually best examined in the arms of a parent. “Stranger anxiety” may be present and could eliminate other assessment options.
- If needed, calm the infant with a pacifier, blanket or favorite toy.

Toddler (1-3 Years):

- Approach the toddler slowly. Keep physical contact at a minimum until he/she feels familiar with you.
- Perform the assessment at the level of the toddler by sitting or squatting next to them and **allow the toddler to remain in the caregiver’s lap** whenever possible.
- Assessment should be **toe to head**. This is less threatening to the toddler.
- Give limited choices such as “Do you want me to listen to your chest or feel your wrist first?”

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Toddler (1-3 Years) {Continued}:

- Use simple, concrete terms and continually reassure the toddler.
- Do not expect the toddler to sit still and cooperate – be flexible.

Preschooler (3-5 Years):

- A preschool aged child is a “magical thinker.” Concrete concepts must be described in short, simple terms.
- A preschooler is often very cooperative during the assessment process and may be able to provide a history.
- Questions should be simple and direct.
- Allow the child to handle equipment.
- Use distractions.
- **Do not lie to the child. If the procedure is going to hurt, tell them.**
- Set limits on behavior (*e.g.* “You can cry or scream, but don’t bite or kick.”).
- Focus on one thing at a time.
- Play games with immobilized preschoolers to distract him/her and prevent them from squirming.

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School Age (5-13 Years):

- The school aged child is usually cooperative and can be the primary sources for the patient history.
- Explain all procedures simply and completely and respect the patient's modesty.
- Substance abuse issues may be present in this age group and should be considered during the care of altered level of consciousness cases.
- Children at this age are afraid of losing control, so let him/her be involved in the care. However, do not negotiate patient care unless the child really has a choice.
- Reassure the child that being ill or injured is not a punishment and praise them for cooperating.

Adolescent (13-16 Years):

- **The adolescent is more of an adult than a child and should be treated as such.** Depending on the nature of the problem, an accurate history may not be possible with parents observing. It may be necessary to separate the parent and child during the assessment.
- Regardless of who is present, respect the patient's modesty. Avoid exposing the adolescent unnecessarily.
- Explain what you are doing and *why* you are doing it!
- Show respect – speak to the adolescent directly. Do not turn to the caregiver for the initial information.

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Assessment of the Pediatric Patient

1. Scene Size-Up

- Note anything suspicious at the scene (*e.g.* medications, household chemicals, other ill family members, etc.).
- Assess for any discrepancies between the history and the patient presentation (*e.g.* infant fell on hard floor but there is carpet throughout the house).

2. General Approach to the Stable/Conscious Pediatric Patient

- Utilize the *PAT (Pediatric Assessment Triangle)* to gain a general impression of the child.
- Assessments and interventions must be tailored to each child in terms of age, size and development.
- Smile, if appropriate to the situation.
- Keep voice at an even, quiet tone – do not yell.
- Speak slowly. Use simple, age appropriate terms.
- Keep small children with their caregiver(s) whenever possible and complete assessment while the caregiver is holding the child.
- Kneel down to the level of the child if possible.
- Be cautious in the use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
- Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, LMP, sexual activity or child abuse.
- ❖ Observe general appearance and determine if behavior is age appropriate.
- ❖ Observe for respiratory distress or extreme pain.
- ❖ Look at the position of the child.
- ❖ What is the level of consciousness?
- ❖ Muscle tone: good vs. limp.
- ❖ Movement: spontaneous, purposeful or symmetrical.
- ❖ Color: pink, pale, flushed, cyanotic or mottled.
- ❖ Obvious injuries: bleeding, bruising, gross deformities, etc.
- ❖ **Determine weight** – ask patient, caregiver(s) or use Broselow tape.

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Assessment of the Pediatric Patient

3. Initial Assessment

- Airway access/maintenance with c-spine control
 - Maintain with assistance: positioning
 - Maintain with adjuncts: oral airway, nasal airway
 - Maintain with endotracheal tube
 - Listen for any audible airway noises (*e.g.* stridor, snoring, gurgling, wheezing)
 - Patency: suction secretions as necessary

- Breathing
 - Rate & rhythm of respirations – compare to normal rate for age and situation
 - Chest expansion – symmetrical?
 - Breath sounds – compare both sides and listen for sounds (present, absent, normal, abnormal)
 - Positioning – sniffing position, tripod position
 - Work of breathing – retractions, nasal flaring, accessory muscle use, head bobbing, grunting

- Circulation
 - Heart rate – compare to normal rate for age and situation
 - Central pulses (*e.g.* brachial, carotid, femoral) – strong, weak or absent
 - Distal/Peripheral pulses (*e.g.* radial) – present/absent, thready, weak or strong
 - Color – pink, pale, flushed, cyanotic, mottled
 - Skin temperature – hot, warm, cool, or cold
 - Blood pressure – use appropriately sized cuff and compare to normal for the age of the child
 - Hydration status – observe anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output, history to determine

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Assessment of the Pediatric Patient

- Disability – Brief Neurological Examination:
 - Assess responsiveness – APGAR or TICLS
 - Assess pupils
 - Assess for transient numbness/tingling
- Expose and Examine:
 - Expose the patient as appropriate based on age and severity of illness.
 - Initiate measures to prevent heat loss and keep the child from becoming hypothermic.

4. Rapid Assessment vs. Focused History & Physical Assessment

- Tailor assessment to the needs and age of the patient.
- Rapidly examine areas specific to the chief complaint.
- *Responsive medical patients:* Perform focused assessment based on chief complaint. A full review of systems may not be necessary. If the chief complaint is vague, examine all systems and proceed to detailed exam.
- *Unresponsive medical patients:* Perform rapid assessment (*i.e.* ABCs & a quick head-to-toe exam). Render emergency care based on signs & symptoms, initial impression and standard operating procedures. Proceed to detailed exam.
- *Trauma patients with NO significant mechanism of injury:* Focused assessment is based on specific injury site.
- *Trauma patients with significant mechanism of injury:* Perform rapid assessment of all body systems and then proceed to detailed exam.

5. Detailed Assessment

- SAMPLE history – acquire/incorporate into physical exam.
- Vital signs (*i.e.* pulse, BP, respirations, skin condition, pulse ox)
- Assessment performed (usually en route) to detect non life-threatening conditions and to provide care for those conditions or injuries

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Assessment of the Pediatric Patient

6. Ongoing Assessment

- To effectively maintain awareness of changes in the patient's condition, repeated assessments are essential and should be performed **at least every 5 minutes on the unstable patient** and **at least every 15 minutes on the stable patient**.

Normal Pediatric Vital Sign Ranges			
	Heart Rate	Respiratory Rate	Blood Pressure
Infant	100-160 bpm	30-60 rpm	> 60mmHg systolic
Toddler	90-150 bpm	24-40 rpm	> 70mmHg systolic
Preschooler	80-140 bpm	22-34 rpm	> 75mmHg systolic
School Age	70-120 bpm	18-30 rpm	> 80mmHg systolic
Adolescent	60-100 bpm	12-16 rpm	> 90mmHg systolic

Critical Thinking Elements

- **Remember: Pediatric patients have extraordinary ability to compensate and may show normal vital signs even though they are in shock.**