PEDIATRIC INITIAL ASSESSMENT - ALS

I. SCENE SIZE-UP

A. Protect from body substance through isolation (glasses, gloves, gown and mask).

B. Assess the scene for safety and take appropriate steps.

C. Determine the mechanism of injury/nature of illness.

1. Note the number of patients.

2. Initiate Mass Casualty Plan, if necessary.
   a. Call for additional personnel and equipment.
   b. Begin triage.

3. Assess for any indication of abuse or neglect of the patient (See policy “Reporting Abused and/or Neglected Patients”)

II. INITIAL ASSESSMENT OF PEDIATRIC PATIENT

A. Assess general impression of child and environment with initial assessment of wellness and general appearance (conduct from a distance). Complete assessment while protecting the cervical spine, if necessary.

1. Determine nature of illness or mechanism of injury.

2. Is child in a life threatening condition? Treat immediately. Refer to Broselow tape if needed.

3. Obtain SAMPLE history and identify any caregivers at scene.

B. Assess child's mental status.

1. Identify yourself and your purpose using age appropriate terms.

2. Initially approach child in non-threatening manner, on their level when appropriate. Initiate touch in a non-threatening manner, before examining child when appropriate.

3. Evaluate child's mental status utilizing Pediatric Coma Scale.

C. Assess airway

1. Responsive Child

PEDIATRIC INITIAL ASSESSMENT (cont.)

a. If child is talking or crying, then assess for adequacy of breathing.
b. If child is not talking or crying, open airway using modified jaw thrust maneuver.

2. Unresponsive Child

a. Open the airway using modified jaw thrust maneuver.
b. Consider use of oral airway.

D. Assess Breathing

1. Non-breathing child

a. Maintain open airway and assist breathing utilizing ventilatory adjuncts and oxygen at the appropriate rate.
b. Suction if necessary.
c. Pulse oximeter

2. Breathing child

a. Look for rise and fall of chest and feel for rate and depth of breathing.
b. Look for use of accessory muscles, nasal flaring, grunting and retractions.
c. Determine adequacy of breathing for age (either too fast or too slow).
d. If breathing is inadequate, assist breathing utilizing ventilatory adjuncts and oxygen at the appropriate rate.
e. Suction if necessary.
f. Pulse oximeter (if indicated)

PEDIATRIC VITAL SIGNS

Weight in kg = (2 x age in years) + 10

Age	**Pulse**	**Systolic Blood Pressure**	**Respiratory Rate**
Neonate (0-30 days)	100-180	> 60	30-60
Infant (31 days - < 1yr)	100-160	> 60	30-60
Toddler (1 yr - < 3 yrs)	90-150	> 70	24-40
Pre-School (3 yrs - < 5 yrs)	80-140	> 75	22-34
School Age (5 yrs – 12 yrs)	70-120	> 80	18-30
Adolescent (> 12 yrs)	60-100	> 90	12-16

PEDIATRIC INITIAL ASSESSMENT (cont.)

E. Assess Circulation

INDICATORS OF HYPOPERFUSION IN CHILDREN

- Cyanosis despite administration of oxygen
- Truncal pallor/cyanosis and coolness
- Hypotension (late sign)
- Bradycardia (ominous sign)
- Weak, thready, or absent peripheral pulses
- No palpable blood pressure
- Decreasing level of consciousness

1. Check brachial or femoral pulse for rate and quality.

2. If none found, check for carotid pulse. If pulseless, start CPR and see appropriate SMO.

3. Assess for central capillary refill.

4. Assess skin condition.

5. Assess and control severe bleeding.

F. Identify priority pediatric patients for immediate transport and initiate interventions as per SMOs.

G. Repeat initial assessment.

1. Every 15 minutes in a stable child.

2. Every 5 minutes in an unstable child.

3. Repeat before beginning detailed physical examination.

H. Initiate measures to prevent heat loss to keep the child from becoming hypothermic.

I. For children with special healthcare needs (CSHN), refer as needed to child's emergency care plan. Understanding the child's baseline will assist in determining the significance of altered physical findings.

PEDIATRIC INITIAL ASSESSMENT (cont.)

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 PAIN SCALE

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