# Pediatric Assessments

Last Modified on 02/22/2023 12:14 pm EST

ANYTIME After Hours

**Pediatric Assessments**

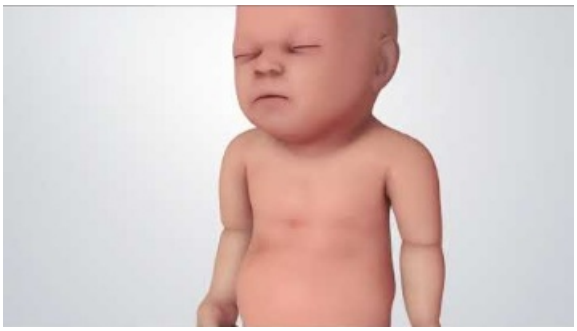
Always paint a clear picture of the patient's symptoms in your documentation. Be sure to include medical history, allergies to medication, and current medications related to the symptoms. Any nurse or provider should be able to see exactly why you landed on your chosen disposition based off your documentation.

Warning Signs in Babies (click for video/sound)

**Retractions**

**Grunting**

**Apnea**



Click links below to hear

0:27 stridor

1:11 wheeze

From <https://www.youtube.com/watch?v=ObZFU3YUqyE>

**Breathing Difficulty**

- Rapid respiratory rates apply to children who are not crying.
- The following RR are abnormally fast:
- Under 2 months:  > 60 breaths per minute

- 2 to 12 months: > 50 breaths per minute
- 1 to 5 years: > 40 breaths per minute
- 6 to 11 years: > 30 breaths per minute
- 12 years or older: > 20 breaths per minute
- When counting respirations over the phone, explain that 1 respiration is an inhale and exhale, set your timer, and ask caller to count for one full minute
- Is the patient working harder to breathe? Do they appear to be struggling?
- Any blueness to lips or face?
- Is the patient awake/alert, normal cry?
- Are their any respiratory noises when they breathe? Does it clear when they cough?
- If patient can cough and the sound clears it is likely congestion, not wheezing
- Ask caller to put patient to phone for you to listen
- Is there any stridor (mimic this sound for the caller)?
- Is the skin sucking in between their ribs when they breathe?
- Are they feeding well, having to take breaks?
- Is there any nasal congestion? Have you tried to suction prior to feeding or sleep?
- Although high fevers can cause small increases in RR, there is no reliable conversion factor.
- If the fever is above 103 F (39.5 C) and the RR is slightly increased above abnormal (and not associated with any increased work of breathing or trouble feeding), a nurse may elect to provide a follow-up call in 1 hour.
- All infants birth to 1 year with a suspected BRUE (brief resolved unexplained event) need to be referred to an ED now for an evaluation.

**Lethargy - usually due to a serious illness such as sepsis**

- What's changed?
- Is patient feeding and sucking well?
- Alert when Awake? Watching tablet or looking at a book?

- Little spontaneous movement
- Decreased eye contact
- Doesn’t seem to recognize the parent; minimal response to stimulation or touch
- Doesn’t interact with the parent or environment; does not play
- Decreased spontaneous talking or babbling
- Doesn’t respond to questions
- Doesn’t follow simple commands

**Pain**

- Location - where does it hurt
- Level - mild/moderate/severe
- Does it wake from sleep?
- Are they consolable?
- Does pain improve with Tylenol or Motrin?
- Characteristic - sharp, dull, achy, throbbing, etc.
- Duration - when did the pain start, how long does it last
- Consistency - does it come and go or is it constant

**Rash**

- Difficulty breathing or swallowing? Rule out anaphylaxis first.
- Allergies?
- Past reactions?
- Taking any medications?
- Recent vaccinations?
- Fever?
- Location

- Duration - when did it start
- Color - pinkish, red, purple or blood colored, pale center
- Description - raised, flat, smooth, splotchy, welts, hives (pale red bumps that resemble mosquito bites), blistered, peeling
- Size - pinpoint, tip of pen or eraser, coin size, palm of hand
- Does it itch?
- Is it painful to touch?

**Alteration in Skin integrity (lump, bruise, laceration, abscess, etc)**

- Location - where is the area located
- Size - coin size, tip of an eraser, pea, grape, marble, lemon, golf ball, etc.
- Pain - tender to touch, can you move normally (see above)
- Redness - surrounding skin, is there a red streak
- Swelling - mild/moderate/severe - double in size, noticeable difference, puffy
- Drainage - see above
- Color - black, white, red, bruised/discolored, blue
- Rash - see above

**Unusual Stool**

- The only colors to worry about are red, black (not dark green) and white.
- "Bloody" stools: 90% of red stools are not caused by blood
- Foods: red Jell-O, red or grape Kool-Aid, red cereals, red cake frosting, red candy, tomato juice or soup, cranberries, beets, red peppers, red licorice, Fire Cheetos, rhubarb, paprika, red food coloring
- Medicines: Amoxicillin or Rifampin and  Omnicef or cefdinir
- Black stools
- Medicines: iron, bismuth (e.g., Pepto-Bismol)
- Having the caller smear a piece of stool on white paper and looking at it under a bright light often confirms that the color is actually dark green.

- White or grey stools
- Foods: milk-only diet
- Medicines: aluminum hydroxide (antacids), barium sulfate from barium enema
- Liver disease or bile duct obstruction: Newborns with blocked bile ducts (biliary atresia) have stools that are light gray or pale yellow