Pediatric Assessment
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Disclosures
Stacey Pollard has no real or perceived conflicts of interest that relate to this presentation.

Objectives
1. Perform an accurate pediatric head-to-toe assessment.
2. Identify physical abnormalities of the pediatric patient.
3. Describe assessment changes as the pediatric patient grows.
4. Perform a pediatric pain assessment.
Goals of a Proper Pediatric Assessment:

• Minimizes stress and anxiety.
• Fosters a trusting nurse-child-parent relationship.
• Allows for maximum preparation of the child.
• Maximize the accuracy and reliability of assessment findings.

Assessment: Key Points

• Begins with inspection of general appearance
  • State of wellness
  • Degree of illness or distress
• Is height and weight proportional?
• Is the child well nourished?
• Is the child's skin color normal?
• Note child’s hygiene
• Do you notice any distinct body odors?
• Is the child lethargic/floppy?
• Do you see any signs of specific illness?
• How are they breathing?

Physical Exam

• If quiet - listen and feel first.
• Proceed in usual head-to-toe direction.
• Perform traumatic procedures last.
• Elicit reflexes as body part is examined.
Skin
- Color
- Texture & turgor
- Edema
- Birth mark/pigmentation
- Temperature
- Infectious lesions
- Capillary bleeding
- Infestations
- Puritis
- Trauma

Head
- Check shape, symmetry and fontanel.
- Note head control and posture.
- Observe the face for general appearance.
- Observe scalp.

Head/Face
- Check eyes
- Check ears
- Observe nose
- Inspect mouth
Keep Going! Chest Assessment

- Get axillary temperature
- Inspect
  - Chest size
  - Shape
  - Symmetry
  - Movement
  - Breast development/irregularities
- Listen

Lungs & Respiratory Status: Key Points

- Symmetry of expansion
- Respiratory rate
- Grunting
- Stridor
- Retractions
- Adventitious sounds: rales (crackles), rhonchi, wheeze

Heart

- Rate, rhythm, heart sounds
- Murmurs
  - Systolic/diastolic or continuous
  - Coarse
  - Harsh
  - Blowing
  - High pitched
  - Swishing
  - Functional murmurs
Pediatric Assessment
Hospice and Palliative Nurses Association (HPNA) E-Learning

Abdomen

• Inspection
• Auscultation and palpation (if not previously performed)
• Observe movement
• Appearance of the umbilicus

Genitorectal Area

• Examine genitalia and skin integrity.
• Males – examine the scrotum, pull back the foreskin if patient is uncircumcised.
• Female – pull apart the labia slightly to visualize the inner part of the vagina.
• Inspect the rectal area for any rashes or abnormalities.

Back

• Listen for lung sounds if you haven’t already.
• Look for:
  • abnormalities with the curvature of the spine
  • skin impairment
Extremities

• Inspect:
  • Symmetry of length, size
  • Ability to move/flex
  • Color
  • Warmth
• Check:
  • Number of fingers and toes
  • Edema or other abnormalities with the skin
  • Reflexes
  • Get a pedal pulse and obtain pulse ox

As They Grow

• Assessment process may change slightly.
• May have to adapt your process to accommodate a fussy or uncooperative child.
• Allow the child to touch and examine your equipment to facilitate familiarity.
• For older children, you may use your usual head-to-toe exam technique as long as child remains cooperative.

Pediatric Assessment:
Older Children

• Vital signs will change.
• Reflexes will change.
• Use your knowledge of adults when assessing the older child.
Pediatric Assessment: Vital Signs

- Respiratory rates:
  - Newborn: 30-60 bpm
  - Children 1-10: 20-40 bpm
  - >10 years old: 15-25 bpm

- Heart Rate:
  - Newborn: 120-160 bpm
  - Children 1-10: 70-120 bpm
  - >10 years old: 60-100 bpm

- Blood Pressure:
  - Premature: 55-75/35-45
  - 0-3 mos: 65-85/45-55
  - 3-6 mos: 70-90/50-65
  - 6-12 mos: 80-100/55-65
  - 1-3 yrs: 90-105/55-70
  - 3-6 yrs: 95-110/60-75
  - 6-12 yrs: 100-120/60-75
  - 12 yrs: 110-135/65-85
Pediatric Assessment: Vital Signs

Normal temperature range
- Rectal 97.9°F to 100.4°F (36.6°C to 38°C)
- Ear 96.4°F to 100.4°F (35.8°C to 38°C)
- Oral 95.9°F to 99.5°F (35.5°C to 37.5°C)
- Axillary 94.5°F to 99.1°F (34.7°C to 37.3°C)

Body Measurements
- Infants are weighed on infant scale
- Children >2 years old weighed on standing scales.
- Height, head and chest circumference done only per physician order

Pain Assessment
- Initial assessment of pain includes:
  - Onset
  - Causes increase/decrease
  - Quality
  - Location
  - Scale used/intensity
  - Duration
Pain Assessment

<table>
<thead>
<tr>
<th>TABLE 1: PEDIATRIC PAIN ASSESSMENT TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Tool</td>
</tr>
<tr>
<td>CRIES (Crying, Restlessness, Irritability, Sleeplessness, Eating)</td>
</tr>
<tr>
<td>Peds (Pediatric Pain Scale)</td>
</tr>
<tr>
<td>FLACC (Face, Legs, Activity, Cry, Consolability)</td>
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<tr>
<td>VAS (Visual Analogue Scale)</td>
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<tr>
<td>Visual Analogue Scale</td>
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</tbody>
</table>

Adapted from references 5 and 7.

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FLACC

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SCORING</th>
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<tbody>
<tr>
<td>FACE</td>
<td>0 - 2</td>
</tr>
<tr>
<td>Legs</td>
<td>0 - 2</td>
</tr>
<tr>
<td>Activity</td>
<td>0 - 2</td>
</tr>
<tr>
<td>Consolability</td>
<td>0 - 2</td>
</tr>
</tbody>
</table>

**FLACC**

- **FACE**
  - 0: No particular expression or smile
  - 1: Occasional frown or smile; withdrawn, disinterested
  - 2: Frequent to constant quivering chin, clenched jaw

- **Legs**
  - 0: Normal position or relaxed
  - 1: Uneasy, restless, tense
  - 2: Kicking, or legs drawn up

- **Activity**
  - 0: Normal activity or motion
  - 1: Sluggish, unusual posture
  - 2: Spinning, falling back and forth, tense

- **Consolability**
  - 0: Content, relaxed
  - 1: Unreassured by occasional touching, hugging or being talked to
  - 2: Difficulty in consoling or comforting

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Wong-Baker Faces Scale

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Very Little</th>
<th>Little</th>
<th>More</th>
<th>Very More</th>
<th>Whole Body</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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</table>
Faces Pain Scale – Revised

Visual Analog Scale – rated 0-10