

Pediatric Nursing Process (PNP)

Preparation and Triage

- Activate team
- Prepare the room and any special equipment
- Don PPE and consider need for decontamination or isolation

Across the Room Observation

- Uncontrolled bleeding? Reprioritize to C-ABC
- Identifies the three components of the Pediatric Assessment Triangle AND categorizes the patient as "Sick, Sicker, or Sickest"

Primary Survey [ABCDEFG] "When you mess, reassess"

A** Alertness (A₁) and Airway (A₂)

- Maintain cervical spinal stabilization (if trauma is suspected)
- AVPU (Alert, Verbal, Pain, Unresponsive)
- Assess airway patency (at least FOUR)

B** Breathing and Ventilation

- Assess breathing effectiveness (at least FOUR)

C** Circulation and Control of Hemorrhage

- Assess central and peripheral pulse, skin color/temperature/moisture and capillary refill (all THREE)
- Assess for uncontrolled hemorrhage, central pulse, skin color/temperature/ moisture and capillary refill (assess all FOUR if trauma)

D** Disability (Neurologic Status)

- Glasgow Coma Scale
- Pupils
- Consider head CT or blood glucose

E* Exposure (E₁) and Environmental Control (E₂)

- Remove clothing and inspect for uncontrolled hemorrhage or obvious signs of illness or injuries
- Provide warmth

**Double-starred items must be completed IN ORDER prior to moving to the next step.
*Single-starred items are essential steps and must be performed, but sequence is not critical.

**Double-starred items must be completed IN ORDER prior to moving to the next step

F Full Set of Vital Signs (F₁) and Family Presence (F₂)

G Get Adjuncts (G₁) and Give Comfort (G₂) [LMNOP]

- L** - Labs: blood typing, blood gases, and lactate
- M** - Monitor
- N** - Naso- or orogastric tube
- O** - Assess pulse Oximetry and capnography (required if sedated or intubated)
- P** - Pain assessment AND management

Reevaluation for Transfer to Pediatric Center or Preparation for Definitive Treatment

Secondary Survey [HI]

H History (H₁) and Head-2-Toe (H₂) Exam

- History (H₁) - Prehospital report, SAMPLE
- Head-2-Toe Assessment (H₂)

I Inspect Posterior Surfaces

- Unless contraindicated by suspected spine or pelvic injury - turn, inspect and palpate, remove backboard

Anticipated Interventions or Diagnostics

- At least THREE

Just Keep Reevaluating

- Vital signs
- Identified injuries and effectiveness of interventions
- Primary assessment
- Pain

Definitive Care or Transport

Emergency Nurse Pediatric Course Study Guide

**Bruce Herman, Emergency Nurses
Association**

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the author's name.

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