

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

Emergency Nurses Association

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1. Understanding the eBook Emergency Nurse Pediatric Course Study Guide
 - The Rise of Digital Reading Emergency Nurse Pediatric Course Study Guide
 - Advantages of eBooks Over Traditional Books
2. Identifying Emergency Nurse Pediatric Course Study Guide
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Emergency Nurse Pediatric Course Study Guide
 - User-Friendly Interface
4. Exploring eBook Recommendations from Emergency Nurse Pediatric Course Study Guide
 - Personalized Recommendations
 - Emergency Nurse Pediatric Course Study Guide User Reviews and Ratings
 - Emergency Nurse Pediatric Course Study Guide and Bestseller Lists

5. Accessing Emergency Nurse Pediatric Course Study Guide Free and Paid eBooks
 - Emergency Nurse Pediatric Course Study Guide Public Domain eBooks
 - Emergency Nurse Pediatric Course Study Guide eBook Subscription Services
 - Emergency Nurse Pediatric Course Study Guide Budget-Friendly Options
6. Navigating Emergency Nurse Pediatric Course Study Guide eBook Formats
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 - Emergency Nurse Pediatric Course Study Guide Enhanced eBook Features
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 - Adjustable Fonts and Text Sizes of Emergency Nurse Pediatric Course Study Guide
 - Highlighting and Note-Taking Emergency Nurse Pediatric Course Study Guide
 - Interactive Elements Emergency Nurse Pediatric Course Study Guide
8. Staying Engaged with Emergency Nurse Pediatric Course Study Guide
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Emergency Nurse Pediatric Course Study Guide
9. Balancing eBooks and Physical Books Emergency Nurse Pediatric Course Study Guide
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Emergency Nurse Pediatric Course Study Guide
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Emergency Nurse Pediatric Course Study Guide
 - Setting Reading Goals Emergency Nurse Pediatric Course Study Guide
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Emergency Nurse Pediatric Course Study Guide
 - Fact-Checking eBook Content of Emergency Nurse Pediatric Course Study Guide
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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