MATERNAL & CHILD NURSING SKILLS CHECKLISTS: PEDIATRIC FOCUS

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MCN SKILLS: PEDIATRIC FOCUS

This booklet is prepared for use on the pediatric component of the Maternal and Child Nursing (MCN) course (N13) in the BS Nursing Curriculum. It is curated for the students of UP College of Nursing for courses involving children and adolescents so that they have an accessible and up-to-date resource. Note that the checklists are made for an ideal setup. Data should be used judiciously depending on the case that you are handling.

HOW TO MAXIMIZE THIS DOCUMENT

Hyperlinks contain the purpose, red flags, and other important data that you need to know regarding the skills including pre, actual, and post-procedure steps, patient/family education, and care considerations. To be able to access these hyperlinks, you should be logged on to your OpenAthens account. Some hyperlinks may also need you to log-in using your UP email account. It is recommended to read and study these before you proceed to implementing the skills checklists.

Aside from integrating these with your lecture and laboratory courses, it is expected that you will eventually use these to assist in proper implementation of these skills in your clinical rotations — both institution-based and community settings. We also curated some templates which will be useful for you during your clinical rotations.

NEWBORN CARE

PERFORMING AN APGAR SCORE

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician orders, and facility protocols on Apgar scoring and initial newborn care and resuscitation.
	Perform standard newborn care throughout the course of Apgar scoring.
	Review patient's medical history/medical record for:
	• Birth history and gestational age at birth
	• Time of birth
	• Current age and weight
	• Maternal factors that may influence newborn’s Apgar score
	• Newborn factors that may influence Apgar score
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Prepare family emotionally. Provide information, encourage questions, and involve caregiver in procedure, as appropriate.
	Procedure Steps
	Provide family-centered developmentally supportive care.
	Note time of delivery and start Apgar timer at exact delivery time, if using.
	Perform brief newborn assessment to determine need for resuscitation or routine care.
	If newborn is preterm or not breathing, crying, or demonstrating good tone, place on resuscitation table or radiant warmer and begin resuscitation according to facility protocol.
	If newborn is born at term, breathing/crying, and demonstrating good tone, dry and warm immediately to prevent heat loss and proceed with routine care.
	Dry, stimulate, and suction newborn’s mouth and noise to clear secretions.
	At 1-minute postdelivery, begin Apgar scoring by assessing pulse. Record score for pulse: Score 2 if heart rate is above 100 beats per minute, score 1 if heart rate is less than 100 beats per minute, or score 0 if pulse rate is absent.

SCORE	0 points	1 point	2 points
Appearance (Skin color)	Cyanotic / Pale all over	Peripheral cyanosis only	Pink
Pulse (Heart rate)	0	<100	100-140
Grimace (Reflex irritability)	No response to stimulation	Grimace or weak cry when stimulated	Cry when stimulated
Activity (Tone)	Floppy	Some flexion	Well flexed and resisting extension
Respiration	Apneic	Slow, irregular breathing	Strong cry

Reference link for the table: https://litfl.com/apgar-score/

	Observe respirations, noting respiratory rate, respiration quality, and strength of newborn’s cry. Record score for respirations: Score 2 if newborn is vigorously crying, score 1 if respirations are slow and irregular, weak, or gasping, or score 0 if respiratory effort is absent.
	Assess muscle tone by extending newborn’s limbs outward and observing how they return to normal flexion. Record score for muscle tone: Score 2 if actively moving all extremities, score 1 if limited movement with some flexion, or score 0 if flaccid or limp.

	Evaluate reflex irritability by flicking sole of a foot or by placing a suction catheter in nares. Record score for reflex response: Score 2 if strong and vigorous, score 1 if grimacing, but not crying, or score 0 if no response.
	Total results of all 5 scores and record Apgar score on Apgar scoring sheet and newborn assessment forms, per facility protocol.
	If score is 7-10, continue with routine care.
	If score is 4-6, perform airway suction and physical stimulation (rubbing back, flicking foot), as needed, to achieve score of 7 or higher.
	If score is 0-3, advanced resuscitation should be underway.
	Repeat Apgar scoring at 5 minutes after delivery. If newborn's score is lower than 7, repeat scoring at 5-minute intervals until 20 minutes from delivery time.
	Postprocedure Steps
	Perform additional scoring if initial scores are low or newborn is at risk for secondary effects of maternal sedatives or analgesics, such as high initial score and low subsequent scores.
	Promptly communicate to treating clinician any critical lab/diagnostic test results.
	Maintain patient safety. For example, position for safety, verify alarms are audible and tubes/lines are functioning properly, and ensure bed is in low position and appropriate size for patient. Reorient patient/family to use of call light, as needed.
	Support family-centered care. Encourage family-child bonding, provide resources for coping, and review unit policies, such as those regarding visitation and caregiver rights.
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact. See specific manufacturer instructions.
	Perform hand hygiene.

WEIGHING A NEWBORN

	Competency Areas
	Preprocedure Steps
	Review manufacturer instructions for supplies to be used. Verify supplies are in good working order.
	Introduce yourself.
	Identify patient using at least 2 unique identifiers (full name, date of birth, medical ID number).
	Provide privacy for patient.
	Follow standard precautions and appropriate aseptic technique. Perform hand hygiene and use personal protective equipment.
	Procedure Steps
	Perform the following to weigh a newborn using an infant scale.
	Position the newborn scale safely, especially if the scale is transportable.
	Line scale with a paper sheet or drape.
	Calibrate scale to the "0" position, referred to as "zero the scale" to subtract the weight of the paper sheet or drape from the final weight measurement.
	Fully undress the newborn, including all clothing, footwear, diaper, and hair accessories or hats.
	Safely place the newborn on the scale.
	Note and record newborn’s weight.
	Carefully remove newborn from scale. Allow parent to re-diaper infant.
	Plot the weight and height measurements on a facility-approved growth curve form.
	Remove the paper sheet/drape and wipe the scale to remove microorganisms using a facility-approved disinfectant and cloth or prepackaged disposable disinfectant wipe.
	Post-procedure Steps
	Maintain patient safety. Follow facility protocol for fall prevention.
	Remove and discard used personal protective equipment and other used materials in proper receptacles.
	Clean equipment if there has been patient contact. See specific manufacturer instructions.
	Perform hand hygiene.
	Note depending on the patient’s health status, continued weight monitoring may be ordered to detect future weight gain or loss.

MEASURING GROWTH: LENGTH, HEAD CIRCUMFERENCE, CHEST CIRCUMFERENCE MEASUREMENT

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician order, and facility protocol for assessing infant growth.
	Review patient's medical history/medical record.
	Ensure equipment is well maintained and correctly calibrated.
	Verify room temperature is adequate for comfort of unclothed infant
	Follow standard precautions and appropriate aseptic technique. Perform hand hygiene and use personal protective equipment.
	Follow standard preprocedure steps for pediatric patients, as appropriate.
	Prepare family emotionally. Provide developmentally appropriate information (as applicable) and encourage questions.
	Procedure Steps
	Use standard aseptic nontouch technique throughout procedure to prevent infection.
	Approach infant in developmentally appropriate manner.
	Safely place the newborn on a flat surface, or along a measuring tape.
	Obtain accurate length measurements making sure that knees are not bent.
	• Measure from top of the head to the bottom of their heel.
	Measure the head circumference of the newborn or infant.
	• Measure with nonelastic tape measure drawn across the center of the forehead and around the most prominent portion of the posterior head (the occiput)
	Measure the chest circumference of the newborn or infant.
	• Measure with nonelastic tape measure around the chest at the level of the nipples
	Disinfect materials which touched the patient.
	Post-procedure Steps
	Maintain patient safety. Follow facility protocol for fall prevention.
	Remove and discard used personal protective equipment and other used materials in proper receptacles.
	Clean equipment if there has been patient contact. See specific manufacturer instructions.
	Perform hand hygiene.
	Document measurements and plot in appropriate charts.

PERFORMING PHYSICAL ASSESSMENT IN CHILDREN

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician orders, and facility protocol for performing a newborn physical assessment.
	Review patient's medical history/medical record for:
	• Birth history
	• Current age and weight
	• Indications for physical assessment
	• Developmental milestones
	• Immunization status
	• Medications, if any
	• Labs/diagnostic test results
	• Allergies, if any
	• Verify completion of informed consent documents
	Verify supplies are in good working order.
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Identify and accommodate any communication needs or specific cultural/religious beliefs that may enhance family-centered care. Be aware of any assumptions you may have to minimize bias.
	Provide privacy for patient.
	Explain procedure and offer support.
	Procedure Steps
	Reduce newborn’s risk for hypothermia by using a radiant warmer or by covering infant in a warm blanket as much as possible during exam.
	Always maintain at least 1 hand on infant for support. Do not step away from an infant lying on a bed, table, or an isolette with sides down.
	Perform an initial physical assessment of newborn beginning with portions that require infant to be most cooperative and quiet, such as heart and lung auscultation, followed by elements of exam that would be most bothersome, such as ears and throat.
	Observe infant’s behavior, positioning, and response to stimuli. Normal infant tone is flexed when active and awake.
	Assess cardiovascular system.
	Auscultate heart and verify maximal cardiac impulse is at 4th to 5th intercostal space, lateral of left sternal border, and S2 heart sound is louder and higher in pitch than S1.
	Assess for presence of innocent heart murmurs, which are present in about 50% of newborns.
	Verify pulse has regular rhythm and rate.
	Assess respiratory system.
	Auscultate lungs, assessing for tachypnea, crackles, wheezes, or other abnormal breath sounds.
	Check for retractions, difficulty breathing, nasal flaring, and grunting.
	Verify abdominal breathing is present, which is characterized by abdomen rather than chest rising and falling with respirations.
	Assess for abnormal respiratory system findings, such as cyanosis in areas other than hands and feet.
	Stop physical exam and intervene if any indications of respiratory distress are noted.

	Competency Areas
	Procedure Steps (Continuation)
	Assess skin.
	Assess head for cephalohematoma or caput succedaneum. Note abnormalities, such as fused sutures, bulging or depressed fontanelles, abnormally shaped facial structures, mandibular hypoplasia, forceps injury, or facial palsy.
	Assess eyes for asymmetry, red reflex, subconjunctival hemorrhage, cataracts, and conjunctivitis.
	Assess ears. Pull down and back.
	Assess nose.
	Assess mouth and throat, including palate (note any cleft lip/palate).
	Assess neck for ROM, shape, and masses. Palpate clavicles for evidence of fractures from birthing process.
	Assess chest.
	Assess abdomen, including for enlargement of liver, spleen, or kidneys.
	Assess genitourinary system.
	Assess extremities, including for fractures, paralysis, weakness, polydactyly, syndactyly, and full ROM in both hips.
	Assess spinal column, including for hairy tufts, deep sacral clefts, or other spinal deformities.
	Assess if anus is patent and whether blackish-greenish meconium is present.
	Assess neurological system throughout exam by evaluating reflexes. Report absence or weakness of a reflex, as well as hypertonia.
	Post-procedure Steps
	Maintain patient safety.
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact.
	Perform hand hygiene.
	Report abnormalities noted during physical assessment of newborn to treating clinician, who will evaluate newborn in more detail.
	Document accordingly.

ADMINISTERING HEPATITIS B VACCINE TO NEWBORN

Before you proceed, read the Manual of Operations of Department of Health (DOH) on the National Immunization Program.

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician orders, and facility protocols on administering hepatitis B vaccine to newborn.
	Review patient's medical history/medical record for:
	• Birth history
	• Maternal hepatitis B status
	• Immunization consent form
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Identify and accommodate any communication needs patient/family may have.
	Identify and accommodate, if possible, any specific cultural and religious beliefs that may enhance care.
	Be aware of any assumptions you may have, and separate your own beliefs and values from those of the patient/family to minimize bias.
	Provide privacy for patient.
	Verify supplies are in good working order and review manufacturer instructions for use.
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Prepare family emotionally. Provide information, encourage questions, and involve caregiver in procedure, as appropriate.
	Procedure Steps
	Perform hand hygiene. Put on nonsterile gloves.
	Verify rights of safe medication administration.
	Assess patient.
	Observe intended vastus lateralis site for any skin abnormalities, such as redness or bruising.

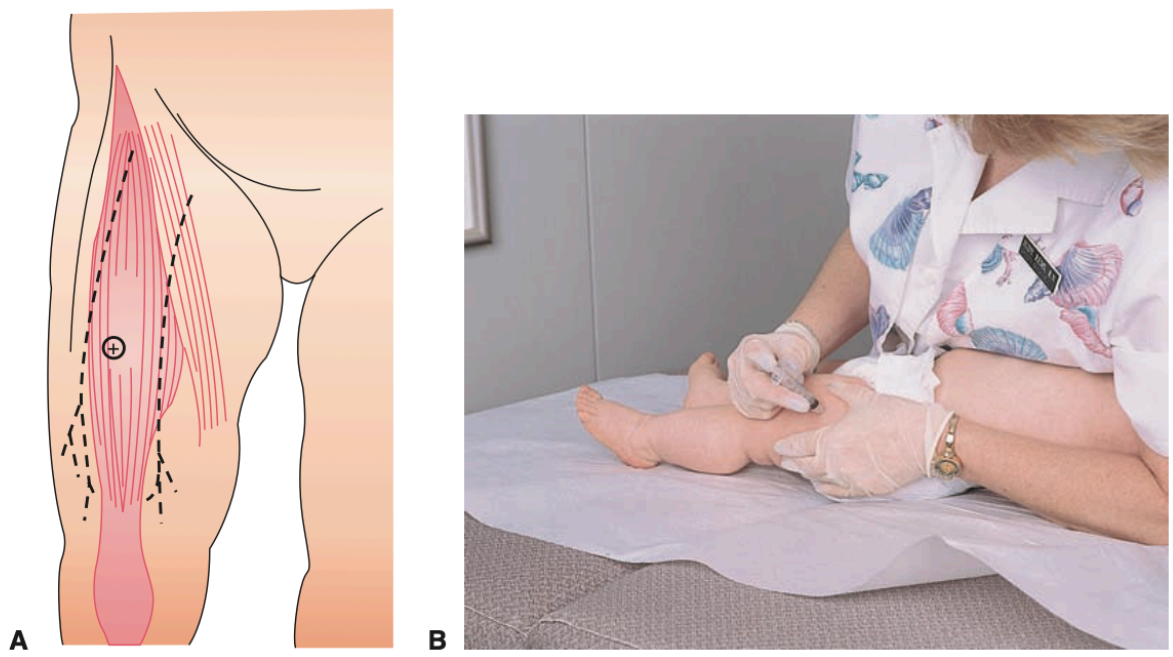

Figure 1. **A**) For infants under walking age, use the vastus lateralis muscle for intramuscular injections. (**B**) Technique for administering an intramuscular injection to an infant. Note the way the nurse uses her body to restrain and stabilize the infant.

	Competency Areas
	Review for any contraindications to vaccines.
	Prepare vaccine.
	Check vaccine color, clarity, expiration date, and package integrity. If expired, label “do not use” and store per facility protocol until removal.
	If not preassembled, clean top of vial with antiseptic swab.
	Insert aspirating needle into stopper of vaccine vial and withdraw prescribed amount of vaccine.
	Remove syringe from vaccine vial.
	Attach appropriate needle tip aseptically.
	Label medication and reverify medication rights, as needed.
	Position patient.
	Implement distraction and pain management techniques.
	Clean injection site with alcohol swab in a circular motion, moving away from site and allow to air dry.
	Inject vaccine.
	• Uncap needle and expel any air.
	• Hold syringe between thumb and forefinger as if holding a dart.
	• Stretch or spread skin with nondominant hand and isolate and hold muscle.
	• Position needle at a 90° angle to surface of injection site.
	• Pierce patient’s skin using a smooth, rapid motion until hub of needle meets patient’s skin.
	• Inject vaccine at rate of 10 seconds per mL, or as indicated by facility and manufacturer.
	• Remove needle smoothly, at same angle of insertion.
	• Engage safety, as available, and dispose of needle and syringe in facility-indicated sharps container.
	• Cover injection site with gauze and apply light pressure until bleeding stops.
	• Engage safety, as available, and dispose of needle and syringe in facility-indicated sharps container.
	Postprocedure Steps
	Document the hepatitis B vaccine administration accordingly.
	Observe patient for 15-30 minutes for signs/symptoms of allergic reaction.
	Involve family in medical rounds and report, per protocol, to improve their knowledge of newborn’s immunization status, possible expected side effects, and hepatitis B vaccine adverse reactions.

ADMINISTERING EYE PROPHYLAXIS IN NEWBORNS

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician orders, and facility protocols on administering eye prophylaxis in newborns.
	Review patient's medical history/medical record for birth history and gestational age at birth; current age and weight; and prenatal care, history of maternal sexually transmitted infections.
	Follow standard preprocedure steps for pediatric patients, as appropriate.
	Prepare family emotionally. Provide information, encourage questions, and involve caregiver in procedure, as appropriate.
	Procedure Steps
	Verify rights of safe medication administration.
	Prepare to apply eye prophylaxis. Put on nonsterile gloves. Moisten sterile gauze pad with sterile saline. Clean newborn's eyes. Open newborn's eye by placing thumb and forefinger of your nondominant hand at corner of each eyelid. Press gently on periorbital ridges.
	Administer eye prophylaxis.
	If applying antibiotic ointment, apply a 1-2 cm (0.39-0.78 inch) ribbon to lower conjunctival sac from inner canthus of eye to outer canthus.
	Do not touch tube to newborn's eye.
	Close newborn's eye.
	Repeat procedure on other eye.
	Use a new, dry sterile gauze pad to wipe away excess ointment after 1 minute.
	Postprocedure Steps
	Assess for signs of chemical conjunctivitis, such as redness, lid edema, or drainage.
	Remove and discard personal protective equipment and other used materials properly.
	Perform hand hygiene.
	Document accordingly.

NEWBORN BATH

	Competency Areas
	Preprocedure Steps
	Check care plan and treating clinician orders on bathing newborn, as available. This should be done at least 6 hours after birth.
	Review newborn's medical history/medical record for birth history, developmental milestones, and immunization status; birthing parent history; thermoregulatory history; risk factors for hypothermia; and contraindications.
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Identify and accommodate any communication needs or specific cultural/religious beliefs that may enhance family-centered care. Be aware of any assumptions you may have to minimize bias.
	Complete remaining preprocedure steps (such as filling basins and lining up equipment) with parent/guardian, as appropriate.
	Ensure room is warm, approximately 26°C-27°C (79°F-81°F).
	Provide privacy for patient.
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Procedure Steps
	Discuss purpose and goals for newborn's first bath with parent/guardian and encourage their participation, as appropriate.
	Fill baby bathing basin.
	Swirl water around, to ensure there are no hot spots.
	Test water with thermometer. It should read 37.7°C or between 37°C and 38°C
	Loosely swaddle newborn.
	Maintain newborn temperature.
	Clean infant's/newborn's eyes with clean or sterile water, per facility protocol, and cotton ball.
	• Use 1 cotton ball per eye.
	• Wipe from inner canthus to outer canthus.
	• Use each cotton ball only once.
	• Swipe eye only once, unless there is crusting or purulence.
	Gently wash infant/newborn in sections, paying special attention to skin folds.
	Wash in this order: upper right, upper left, trunk, lower right, lower left, head and neck, hair, genital area, and buttocks and anus.
	If any remaining vernix caseosa, it is not necessary to remove, as it provides a protective barrier for infant/newborn.
	Wet a washcloth with warm bathwater.
	Lather washcloth with cleanser.

	Competency Areas
	Remove only section of blanket covering area to be cleaned.
	Rotate washcloth to a new section of washcloth or change washcloths as needed.
	Replace with blanket.
	Observe and assess newborn’s skin and behavior.
	Observe for any signs/symptoms of hypothermia.
	Look for signs/symptoms of infection, skin breaks, breakdown, or irritation. This might include redness, pain, drainage, odor, swelling, loss of motor function, fever, and malaise.
	If any of these are seen, dry and wrap infant/newborn, as appropriate, and contact treating clinician.
	IF CLEANSING OR SHAMPOOING NEWBORN’S HAIR:
	Gently lather a small amount of shampoo/cleanser over newborn’s entire scalp.
	Rinse newborn’s scalp, starting at forehead and sweeping back. Be sure to avoid getting water in newborn’s face.
	Ensure shampoo is rinsed off fully.
	Dry hair and scalp completely.
	Gently wash genital area.
	If newborn has a vagina, wash vulva anteriorly to posteriorly to avoid contamination of genital area.
	If newborn has a penis, wash penis proximally from head of penis.
	If newborn has a recently circumcised penis, use warm bathwater or sterile water, per facility protocol, and apply petroleum jelly, petroleum-coated gauze, or topical medication, as ordered and appropriate.
	Gently wash buttocks and anus last.
	Dry infant/newborn fully.
	Pat dry. Rubbing can irritate infant’s/newborn’s sensitive skin.
	Diaper and dress infant/newborn.
	Brush or comb newborn’s hair gently and apply a cap.
	Swaddle newborn and encourage parent/guardian to hold and provide skin-to-skin to newborn, as appropriate.
	Postprocedure Steps
	Monitor patient for signs/symptoms of hypothermia.
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact.
	Perform hand hygiene.
	Document accordingly

BATHING INFANTS OR NEWBORNS (TUB BATH)

	Competency Areas
	Preprocedure Steps
	Check care plan and treating clinician orders on bathing infant/newborn, as available.
	Review infant/newborn's medical history/medical record for birth history, developmental milestones, and immunization status; birthing parent history; thermoregulatory history; risk factors for hypothermia; and contraindications.
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Identify and accommodate any communication needs or specific cultural/religious beliefs that may enhance family-centered care. Be aware of any assumptions you may have to minimize bias.
	Complete remaining preprocedure steps (such as filling basins and lining up equipment) with parent/guardian, as appropriate.
	Ensure room is warm, approximately 26°C-27°C (79°F-81°F).
	Provide privacy for patient.
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Procedure Steps
	Discuss purpose and goals for infant/newborn's bath with parent/guardian and encourage their participation, as appropriate.
	Fill baby bathing basin with enough water to cover infant's/newborn's hips, or per facility protocol.
	Swirl water around, to ensure there are no hot spots.
	Test water with thermometer. It should read 37.7°C or between 37°C and 38°C
	Undress infant/newborn.
	Quickly assess infant/newborn per facility protocol. If any abnormalities or concerns, consult with treating clinician.
	Loosely swaddle infant/newborn.
	Slowly lower infant/newborn into basin, feet first.
	Maintain infant/newborn temperature.
	Allow infant/newborn to acclimate to new environment. The infant/newborn should be in the bath for 5-10 minutes.
	Have parent/guardian gently pour warm water over infant's/newborn's abdomen, as appropriate.
	Clean infant's/newborn's eyes with clean or sterile water, per facility protocol, and cotton ball.
	• Use 1 cotton ball per eye.
	• Wipe from inner canthus to outer canthus.
	• Use each cotton ball only once.
	• Swipe eye only once, unless there is crusting or purulence.
	Gently wash infant/newborn in sections, paying special attention to skin folds.
	Wash in this order: upper right, upper left, trunk, lower right, lower left, head and neck, hair, genital area, and buttocks and anus.
	Avoid umbilical cord stump, simply washing around it, per facility protocol.
	If any remaining vernix caseosa, it is not necessary to remove, as it provides a protective barrier for infant/newborn.
	Wet a washcloth with warm bathwater.
	Lather washcloth with cleanser.

	Competency Areas
	Remove only section of blanket covering area to be cleaned.
	Rotate washcloth to a new section of washcloth or change washcloths as needed.
	Rinse with a dipper of water.
	Replace with blanket.
	Observe and assess infant's/newborn's skin and behavior.
	Observe for any signs/symptoms of hypothermia.
	Look for signs/symptoms of infection, skin breaks, breakdown, or irritation. This might include redness, pain, drainage, odor, swelling, loss of motor function, fever, and malaise.
	If any of these are seen, dry and wrap infant/newborn, as appropriate, and contact treating clinician.
	IF CLEANSING OR SHAMPOOING INFANT'S/NEWBORN'S HAIR:
	Gently lather a small amount of shampoo/cleanser over infant/newborn's entire scalp.
	Rinse infant/newborn's scalp, starting at forehead and sweeping back. Be sure to avoid getting water in infant/newborn's face.
	Ensure shampoo is rinsed off fully.
	Dry hair and scalp completely.
	Gently wash genital area.
	If infant/newborn has a vagina, wash vulva anteriorly to posteriorly to avoid contamination of genital area.
	If infant/newborn has a penis, wash penis proximally from head of penis.
	If infant/newborn has a recently circumcised penis, use warm bathwater or sterile water, per facility protocol, and apply petroleum jelly, petroleum-coated gauze, or topical medication, as ordered and appropriate.
	Gently wash buttocks and anus last.
	Dry infant/newborn fully.
	Pat dry. Rubbing can irritate infant's/newborn's sensitive skin.
	Diaper and dress infant/newborn.
	Brush or comb infant's/newborn's hair gently and apply a cap.
	Swaddle infant/newborn and encourage parent/guardian to hold and provide skin-to-skin to infant/newborn, as appropriate.
	Postprocedure Steps
	Monitor patient for signs/symptoms of hypothermia.
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact.
	Perform hand hygiene.
	Document accordingly

ASSESSING CHILDREN

VITAL SIGNS IN NEWBORNS, INFANTS, & CHILDREN

	Competency Areas
	Preprocedure Steps
	Check care plan and treating clinician orders on bathing infant/newborn, as available.
	Review infant/newborn's medical history/medical record for birth history, developmental milestones, and immunization status; birthing parent history; thermoregulatory history; risk factors for hypothermia; and contraindications.
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Procedure Steps
	Count the **respiratory rate** of the child for a full minute. Notes • Respirations also should be measured before an infant is disturbed because the respiratory rate increases with crying. • Take this while a child is sitting in a parent's lap or lying quietly in a crib before lowering the side rail if possible. • Infants tend to breathe with their abdominal muscles; therefore, it is as accurate to take respirations by counting movements of the abdomen as it is to count chest movements.
	Obtain the **temperature** of the child. Notes • Tympanic temperature measurement may not be ideal for newborns because ears may contain vernix. • Rectal temperature should never be used in newborns because of the risk of damaging rectal mucosa! • Because preschoolers generally fear intrusive procedures, consider taking axillary or tympanic temperatures in children until 4 or 5 years of age. • Tympanic membrane temperature is not affected by the presence of earwax, so it gives consistently accurate results. • By 4 years of age, children are usually old enough to close their mouth sufficiently for oral temperature recording by an electronic thermometer.

	• Most ideal is tympanic temperature measurement.
	  • Insert the tip of the tympanic thermometer gently into the child's ear canal
	  • Straighten the ear canal by pulling down on the earlobe in a child younger than age 2 and pulling up on the pinna of the child older than age 2. *Rationale: This directs the sensor beam toward the center of the tympanic membrane and not the sides of the canal.*

	• Procedure for axillary temperature measurement:
	  • Place the tip of an electronic thermometer in the axilla
	  • Hold the child's arm down to the side to keep the thermometer firmly in place until it registers.

	• For the rare occasions when a rectal temperature must be taken:
	  • Insert a thermometer only to the length of the bulb (½ inch) in infants and not over 1 inch in older children
	  • Hold in place until it registers.

	Count the **pulse rate** of the child for a full minute. Notes • As children grow older, the heart rate slows and the range of normal values narrows. • If possible, measure a child's pulse rate at rest. • An apical pulse (listening at the heart apex through a stethoscope) is taken in children younger than 1 year because their radial (wrist) pulse is too faint to be pal- pated accurately. • In an infant, the point of maximum intensity, or the point on the chest wall where the heartbeat can be heard most distinctly, is just above and outside the left nipple (just lateral to the midclavicular line at the third or fourth intercostal space). This point gradually becomes more medial and slightly lower up to 7 years of age. By 7 years, it is at the fourth or fifth interspace at the midclavicular line.

	Competency Areas
	Obtain the **blood pressure** of the child. Notes • Blood pressure is included in the routine physical assessment of all children older than 3 years of age. • Offer a good explanation of the procedure, especially to young children, because wrapping their arm and applying pressure can be frightening if they are not prepared for it. • The cuff used should be no more than two-thirds and not less than one-half the length of their upper arm • Watching the digital readout numbers is interesting for preschoolers. • In infants younger than 1 year, the thigh and arm blood pressure should be equal. In children older than 1 year, the systolic pressure in the thigh tends to be 10 to 40 mm Hg higher, while diastolic pressure remains the same. If the thigh blood pressure reading is lower than that in the arm, suspect that coarctation of the aorta or an interference with circulation to the lower extremities may be causing this. • When assessing blood pressure, be certain to pay attention to the pulse pressure. >50mmHg or <10mmHg may suggest congenital heart defect.
	Postprocedure Steps
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact.
	Perform hand hygiene.
	Document accordingly.

ASSESSING PAIN IN INFANTS, CHILDREN, AND ADOLESCENTS

	Competency Areas
	Preprocedure Steps
	Check care plan, treating clinician orders, and facility protocol for pain assessment in infants, children, and adolescents.
	Review patient's medical history/medical record for:
	• Birth history, developmental milestones, and immunization status
	• Current age and weight
	• History of conditions associated with acute or chronic pain
	Current medications, including analgesics and last dose
	Most recent lab test results and imaging studies
	Allergies (use alternatives, as appropriate)
	Introduce yourself to patient/family.
	Identify patient using at least 2 unique identifiers (such as full name and medical ID number). Be alert to similar names, lack of name, and same birthdays on unit.
	Identify and accommodate any communication needs patient/family may have.
	Identify and accommodate, if possible, any specific cultural and religious beliefs that may enhance care. Be aware of any assumptions you may have, and separate your own beliefs and values from those of the patient/family to minimize bias.
	Provide privacy for patient.
	Explain procedure and offer support. Be sensitive to family's expressions of guilt, grief, or anxiety.
	Verify completion of informed consent documents, if appropriate.
	Request help from another clinician and arrange for presence of a child life specialist for invasive procedures, if possible.
	Verify supplies are in good working order and review manufacturer instructions for use.
	Perform hand hygiene. Use personal protective equipment and appropriate aseptic technique.
	Prepare child/family emotionally. Provide developmentally appropriate information (as applicable) and encourage questions.
	Procedure Steps
	Approach child in developmentally appropriate manner.

Assess existing pain using **pain assessment tool** for nonverbal/preverbal children or tool for pediatric patients aged 3 years or more, as appropriate.

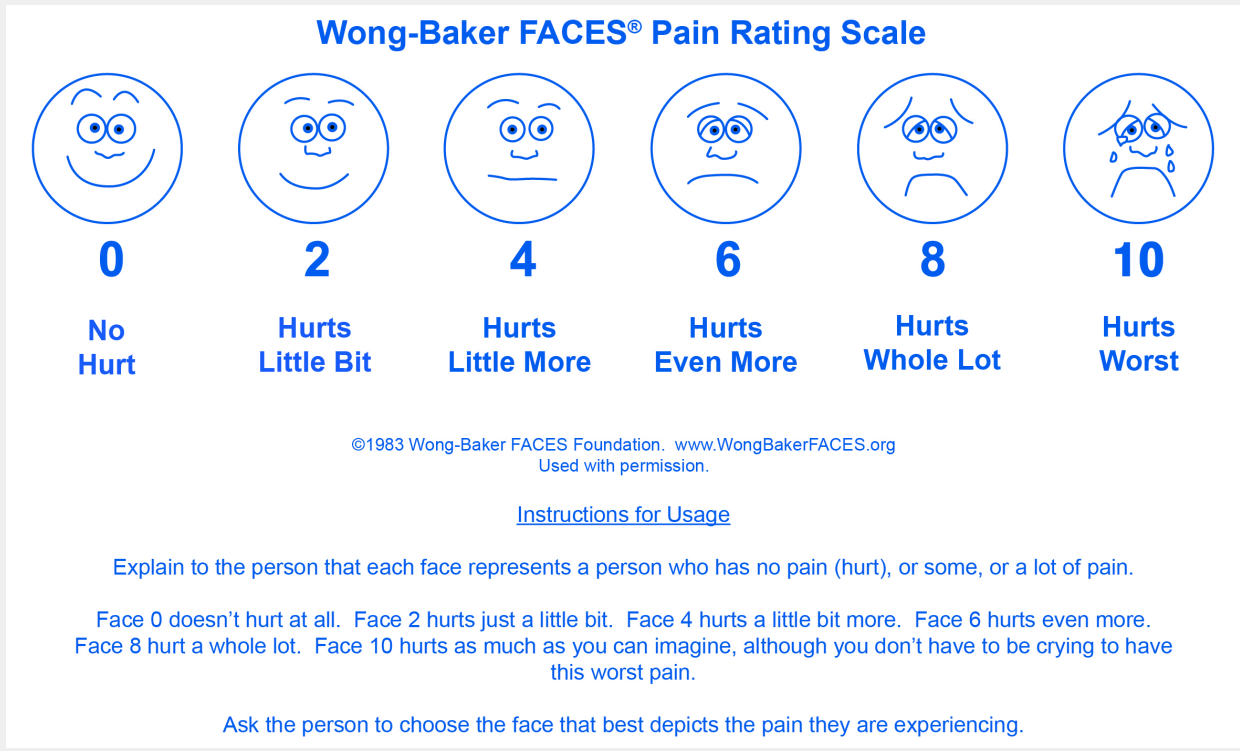

Figure 2. Wong-Baker FACES Pain Rating Scale.

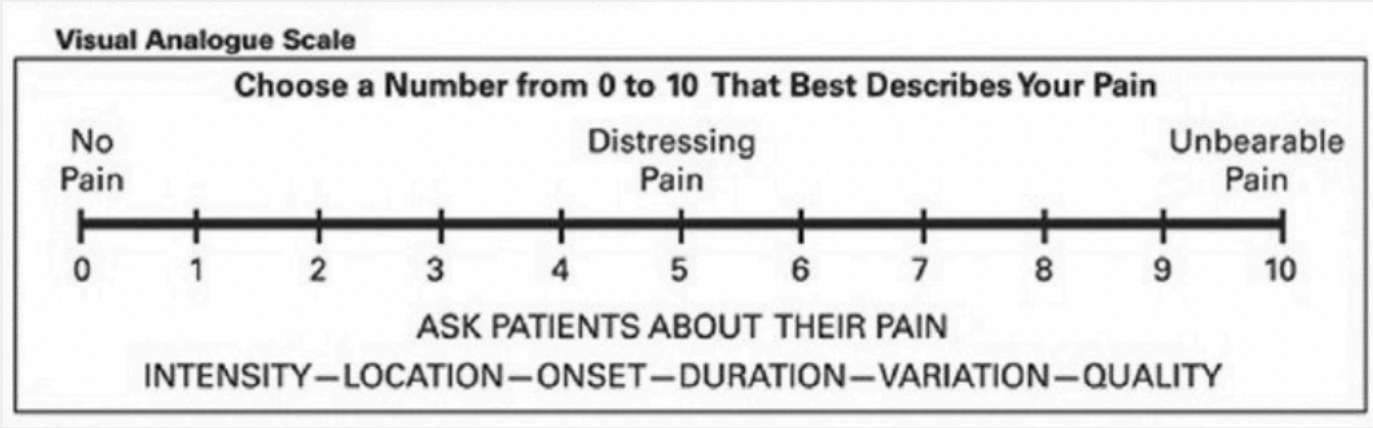

Figure 3. Visual Analogue Scale (VAS)

If child is nonverbal or unable to fully communicate, use behavioral pain scale such as FLACC scale.

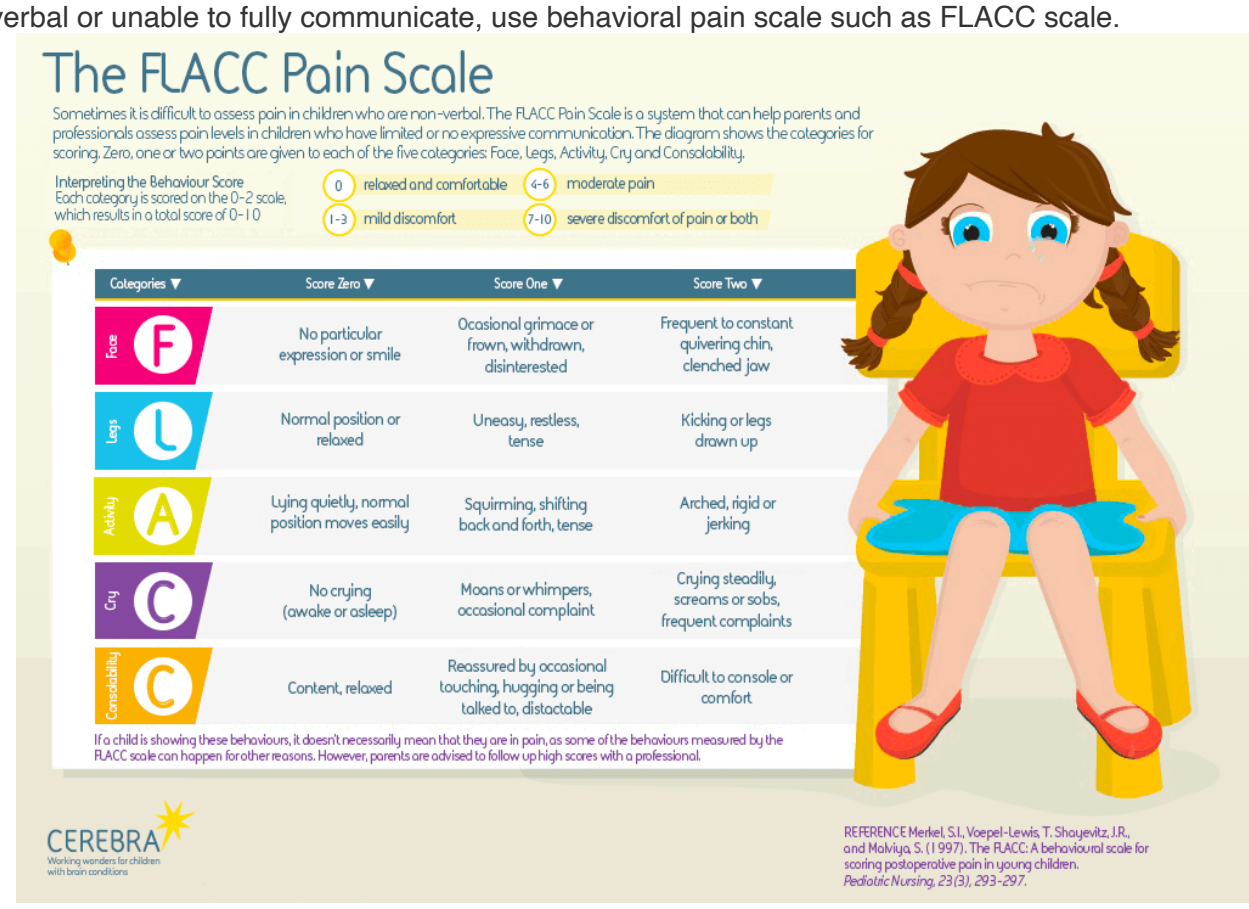

Figure 4. FLACC Scale

Ask patient and caregiver about:

	• Ability to sleep and perform ADLs
	• Previously used interventions and whether they relieved pain
	• History of conditions associated with acute or chronic pain
	• What triggers pain
	• What pain feels like (use developmentally appropriate words, such as “ouch” or “boo-boo”, if indicated)
	• Whether pain increases or decreases at different times of day
	Assess for:
	• Verbal pain cues, such as moaning and crying
	• Change in usual behavior, restlessness, or reduced activity
	• Physical signs, such as grimacing, guarding, abnormal gait, or muscle tension
	• Diaphoresis
	• Constipation, nausea, or vomiting
	• Sleep disturbances
	• Headache
	• Increased blood glucose level
	Inspect painful area for discoloration, swelling, drainage.
	Perform physical exam to assess for potential causes of discomfort.
	Take patient’s vital signs and monitor for increased BP, respiration, and heart rate.
	Assess for common causes of pediatric pain.
	Postprocedure Steps
	Reassess pain at regular intervals using pain assessment tool.
	Collaborate with treating clinician to adjust child’s pain management plan based on findings of these reassessments.
	Maintain patient safety.
	Support family-centered care.
	Remove and discard personal protective equipment and other used materials properly.
	Clean equipment if there has been patient contact. See specific manufacturer instructions.
	Perform hand hygiene.
	Document accordingly.

MMDST ADMINISTRATION CHECKLIST

It is vital to review the Metro Manila Development Screening Test Procedure prior to implementing this on your clients.

- [Form] Metro Manila Developmental Screening Test

	Competency Areas
	Preprocedure Steps
	Make sure that the child can see and reach test materials easily
	Explain the purpose of MMDST
	Explain that the child is not expected to perform everything asked of them
	Calculate age of a child after asking parents the child's birth date
	Before drawing age line, identify if the child is born prematurely
	Draw the age line correctly
	Indicate the date test was administered at top of age line
	Procedure Steps
	Assure cooperation of the child
	• Give child a chance to become used to the examiner
	• Start each sector of test with items the child could pass
	• Tell child what to do rather than asking
	• Clear table of materials which are not being used
	• Ask leading questions when asking parent's report (e.g. suggest answer)
	• Praise the child ONLY when he correctly performed an item
	• Ask the parent if the behavior of child is typical of their behavior
	• Give enough items (at least 3 passes and 3 failures in each sector)
	Postprocedure Steps
	Shades right end of bar to emphasize delays
	Indicate delays only on those items failed which were completely to the left of age line
	Interpret test performance correctly
	Write observations on back of form

HEEADSSS 3.0

The psychosocial interview for adolescents updated for a new century fueled by media

H: Home
E: Education and Employment
E: Eating
A: Activities
D: Drugs
S: Sexuality
S: Suicide/ Depression
S: Safety

Helpful Tips

- Your attitude matters: friendly, open and non- judgmental, ensures confidentiality and privacy
  - Respectful of adolescent's point of view; doesn't trivialize concerns, doesn't preach
- Listen actively
- Encourage the adolescent to talk
  - "Yes go on…", nodding
  - Use open ended question: "Tell more about…"
  - Reflective listening: "It seems to me like…"
  - Convey empathy: "It must been been difficult…"
  - Don't ask "Why?"
  - Don't interrupt
  - Don't use jargon- keep language simple
- Confidentiality is KEY to engagement
  - Define the basis of confidentiality and its limits
  - Have a form of words: What we will be talking about will remain private or confidential. "What do you understand by…?"
  - "Everything is confidential, except (1) Harm to self, (2) Harm to others, (3) Abuse
- Tips on nonverbal cues
  R: Relaxed manner
  O: Open posture
  L: Lean forward
  E: Eye contact
  S: Seating squarely; if this may seem threatening, sitting to the side is an alternative
- Sensitive questions
  - Introduce, normalize
    - "I ask all my patients these questions…"
    - "Some of these questions may make you uncomfortable…"
  - Third person approach
    - "Teens your age experiment with tobacco/ alcohol. Do any of your classmates or friends...? How about you?"

	Competency Areas
	Preprocedure Steps
	Prepare for the interview. (See above for Helpful Tips on attitude, listening, and sitting)
	Procedure Steps
	Introduce yourself to adolescent
	Ask adolescent to introduce companion/s. *Do not assume.*
	Discuss the format of the consultation
	Define confidentiality and limits
	See the patient alone for the interview
	(Home) Opening Line: Where do you live and who lives with you?
	(Education/Employment): Tell me about school or What do you enjoy about school?

	(Activities) What do you and your friends do for fun?
	(Drugs) Do any of your friends use drugs or alcohol? How about you?
	(Sexuality) Younger teen: Tell me about any of your friends who are starting to be in romantic relationships. Older teen: Tell me about any romantic relationships you have been involved in.
	(Suicide/ Depression) Over the past 2 weeks, how often have you felt down, depressed or hopeless? Had little pleasure doing things?
	(Safety) Have you ever had a serious injury? Is there violence in school, neighborhood, friends, family? Are you a member of a gang?
	Wrap-up
	• Ask for concerns and feedback

	• Summarize and prioritize
	  • For those with risk factors, relay your concerns
	  • For those doing well, recognize and commend
	  • SAFETY is top priority

	• Discuss plans with adolescent
	• Discuss issues that need disclosure/ negotiate
	• Call back the parent/ guardian & summarize plans
	• Ask if there are questions
	• Set a follow-up
	• Thank the adolescent and the parent
	• Discuss plans with adolescent
	• Discuss plans with adolescent
	• Discuss plans with adolescent
	• Discuss plans with adolescent

USEFUL VIDEOS & OTHER LINKS

- [Video] Establishing Rapport (Newborn & Infant)
- [Video] Establishing Rapport (Young Children)
- [Video] Establishing Rapport (Adolescent)
- [Video] Head-to-toe assessment (Infant)
- [Video] Head-to-Toe Assessment (Child)
- [Video] How to use ECCD
- [Video] HEEADSSS appropriate practice
- [Slide Deck] Introduction to Pediatric Nursing
- [Link] CDC Developmental Milestones (2 months to 5 years old)

TEMPLATES

- General Pediatric Assessment Form

For other age groups, you may integrate other appropriate assessment in the previous pages or attach the documents below in the General Pediatric Assessment Form:

- [Sample Document] Mother & Baby Book . *Note: Implement the version used in your health center.*
- [Form] Well-baby Assessment Form
- [Checklist] Early Childhood Care and Development (ECCD) for 3 years 1 month to 5 years
- [Form] Pre-schooler Assessment Form
- [Form] School-age Assessment Form

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