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ENPC

Emergency Nursing Pediatric Course

6 th Edition

Notetaking Guide

UPDATED FOR VIRTUAL or ONSITE COURSES

This guide includes basic notetaking pages that follow with the ENPC 6th edition lectures as well as the ENA handouts that will be utilized during the course.

ENPC 6th Edition Handouts

Table of Contents

Pediatric Nursing Process (PNP)

Preparation and Triage

- Activate the team and assign roles
- Prepare the room and any special equipment
- Don PPE, consider potential safety threats to the team or need for decontamination

General Impression

- Assess the three components of the Pediatric Assessment Triangle (PAT), AND categorize the patient as "sick, sicker, or sickest"
- Assess for uncontrolled hemorrhage or unresponsiveness/apnea and the need to reprioritize to C-ABC

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

A Alertness (A_1) and Airway (A_2)**
- 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 pulse, skin color/temperature/moisture, and capillary refill (all THREE)
- Anticipate goal-directed therapy for shock

D Disability (Neurologic Status)**
- Glasgow Coma Scale
- Pupils
- Obtain blood glucose with any altered mental status*

E Exposure (E_1) and Environmental Control (E_2)**
- Remove all clothing and inspect for obvious signs of illness or injury
- 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 (F_1) and Family Presence (F_2)

G Get Adjuncts (G_1) and Give Comfort (G_2) [LMNOP]
- **L** – Labs
- **M** – Monitor
- **N** – Naso- or orogastric tube
- **O** – Oxygenation and capnography
- **P*** – Pain assessment AND management

Reevaluation for Transfer to Pediatric Center or Preparation for Definitive Treatment

Secondary Survey [HI]

H History (H_1) and Head-to-Toe (H_2) Exam
- History (H_1) – Prehospital report, SAMPLE
- Head-to-Toe Assessment (H_2)

I* Inspect Posterior Surfaces
- Unless contraindicated by suspected spine or pelvic injury – turn, inspect, and palpate

Anticipated Interventions or Diagnostics

- At least THREE

Just Keep Reevaluating

- **V**ital signs
- **I**dentified abnormalties and effectiveness of interventions
- **P**rimary survey
- **P**ain

Definitive Care or Transport

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
Preparation and Triage			
1. Activate the team and assign roles			
"Is there any specific equipment that you would prepare?"			
2. Prepare the room	May include, but not limited to, the following: • Length-based resuscitation tape • Pediatric equipment • Pediatric protocols and dosing guidelines • Scale		
3. Don PPE	Consider potential safety threats to the team or need for decontamination.		
"The patient has just arrived."			
General Impression			
4. Assess the three components of the Pediatric Assessment Triangle (PAT) AND categorize the patient as "sick, sicker, or sickest" • Appearance • Work of breathing • Circulation to the skin	No alterations in the PAT = sick One alteration in the PAT = sicker Two or more alterations in the PAT = sickest		
5. Assess for obvious uncontrolled external hemorrhage or unresponsiveness/apnea and the need to reprioritize to C-ABC	When alterations are identified, intervene as appropriate and reassess. May include, but not limited to, the following: • Assess for a pulse • Control external hemorrhage • Initiate chest compressions		
Primary Survey			
Alertness and Airway with Simultaneous Cervical Spinal Stabilization			
6. Assess level of consciousness using AVPU		**	
7. Open the airway	May include, but not limited to, the following: • If cervical spinal injury is suspected, provide manual cervical spinal stabilization AND demonstrate manual opening of the airway using the jaw-thrust maneuver. • When no trauma is suspected, open the airway with a head tilt-chin lift or jaw thrust maneuver. • When the patient is alert and can cooperate, it is acceptable to ask the patient to open their mouth to assess the airway.		

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
8. Assess the patency and protection of the airway (identify at least FOUR): • Bony deformity • Edema • Fluids (blood, vomit, or secretions) • Foreign objects • Loose or missing teeth • Sounds (snoring, gurgling, or stridor) • Tongue obstruction • Vocalization	When alterations are identified, intervene as appropriate and reassess. May include, but not limited to, the following: • Anticipate the need for intubation • Insert an oral or nasopharyngeal airway • Place padding under shoulders/torso • Position patient to optimize airway • Remove any loose teeth or foreign objects • Suction the airway	**	
Breathing and Ventilation			
9. Assess breathing effectiveness (identify at least FOUR): • Breath sounds • Depth, pattern, and general rate of respirations • Increased work of breathing ◦ Abnormal positioning ◦ Grunting ◦ Head bobbing ◦ Nasal flaring ◦ Retractions/accessory muscle use ◦ Tachypnea • Open wounds or deformities • Skin color • Spontaneous breathing • Subcutaneous emphysema • Symmetrical chest rise	When alterations are identified, intervene as appropriate and reassess. May include, but not limited to, the following: • Anticipate need for a chest tube • Anticipate need for drug-assisted intubation • Anticipate need for medications • Anticipate need for decompression of pneumothorax • Anticipate need for oxygen • Provide bag-mask ventilations	**	
10. If intubated, assess endotracheal tube placement (must identify ALL THREE): i. Attach a CO_2 detector device; after 5 to 6 breaths, assesses for evidence of exhaled CO_2 ii. Simultaneously observe for rise and fall of the chest with assisted ventilations iii. Auscultate over the epigastrium for gurgling AND lungs for bilateral breath sounds	If the learner chooses a capnography sensor instead of the one-time-use detection device, credit is given in Step 23.	**	
11. If intubated, assess ETT position by noting the number at the teeth or gums AND secure the ETT			
12. If intubated, begin mechanical ventilation or continue assisted ventilation			
Circulation and Control of Hemorrhage			

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
13. Assess circulation (must identify ALL THREE): • Assess capillary refill • Inspect AND palpate the skin for color, temperature, and moisture • Palpate a pulse	When alterations are identified, intervene as appropriate and reassess. May include, but not limited to, the following: • Anticipate goal-directed therapy for shock • Apply a cardiac monitor – credit given in Step 21 • Apply a pelvic binder • Assess patency of prehospital IV line • Compare central and peripheral pulses • Consider sources of internal hemorrhage • Control external hemorrhage • Draw labs – credit given in Step 20 • Facilitate FAST and/or radiographs to identify source of internal hemorrhage • Initiate chest compressions and advanced life support • Obtain IV or IO access ◦ Two sites may be needed ◦ To administer a fluid bolus, determine weight in kilograms ◦ Use the push-pull, rapid infuser, or other method as appropriate for patient weight and IV access ◦ 20 mL/kg for infant/child ◦ 10–20 mL/kg for blood depending on component (packed cells or whole) ◦ 10 mL/kg with frequent reassessments for neonates, cardiogenic shock, or other risk of volume overload • Palpate central pulse if peripheral pulse is absent	**	
Disability (Neurologic Status)			
14. Assess neurologic status using the GCS: • Best eye opening • Best verbal response • Best motor response	When alterations are identified, intervene as appropriate and reassess. May include, but not limited to, the following: • Assess bedside glucose (* with altered mental status) • Anticipate the need for drug-assisted intubation • Anticipate the need for a head CT NOTE: The GCS is documented as non-testable if there is a factor, such as sedation or paralytics, interfering with communication.	**	
15. Assess pupils			
Exposure and Environmental Control			
16. Remove all clothing AND inspect for obvious abnormalities or injuries	When newly identified life-threatening alterations are identified, intervene as appropriate and reassess. If a transport device is in place, it may be removed. If there are no contraindications, the patient may be turned to quickly assess the posterior. This is deferred until after the head-to-toe and imaging to evaluate spinal and pelvic stability as indicated.	**	

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
17. Provide warmth (identify at least ONE): • Blankets • Increase room temperature • Warmed fluids • Warming lights			
NOTE: During testing, if the learner did not intervene to correct life-threatening findings in the primary survey and/or did not complete all double-starred criteria, the instructor will review the primary survey and notify the course director.			
Full Set of Vital Signs and Family Presence			
18. Obtain a full set of vital signs and weight in kilograms (if not determined earlier)	• BP / mm Hg • HR beats/minute • RR breaths/minute • T °F (°C) • SpO_2 % • Weight kg		
19. Facilitate family presence			
Get Adjuncts and Give Comfort (LMNOP)			
20. L – Consider the need for laboratory analysis	May include, but not limited to, the following: • Blood gases • Blood glucose • Blood cross/type and screen • Coagulation studies • Complete blood count • Cultures • Lactate • Metabolic panel • Pregnancy • Toxicology screen		
21. M – Attach patient to a cardiac monitor	Set monitor to record frequent blood pressures as indicated Consider need for 12-lead ECG – credit given in Step 45		
22. N – Consider the need for insertion of a naso- or orogastric tube	Consider venting pre-existing feeding tubes when the patient is intubated or if the abdomen is distended.		
23. O – Assess oxygenation and continuous end-tidal capnography (if available)	May include, but not limited to, the following: • Increase or decrease rate of assisted ventilation • Wean oxygen (consider parameters other than oximetry due to hypothermia, vasoconstriction, and skin color's impact on pulse oximetry measurements) NOTE: Capnography is highly recommended for all patients and is vital for sedated or ventilated patients.		
24. P – Assess pain using an appropriate pain scale		*	

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
25. Give appropriate nonpharmacologic comfort measures (identify at least ONE): • Distraction • Family presence • Places padding over bony prominences • Repositioning • Splinting • Verbal reassurance • Other, as appropriate	NOTE: Applying ice to swollen areas may be appropriate but consider hypothermia risk for major trauma and very small pediatric patients. Warmth may also be appropriate, but consider burn risk.		
26. Consider obtaining order for analgesic medication			
Consideration of Need for Definitive Care			
"Is there a need to consider transfer to a pediatric-capable facility, surgery, or critical care?"			
Secondary Survey			
History and Head-to-Toe			
27. Obtain pertinent history (identify at least ONE): • Medical records/documents • Prehospital report • SAMPLE			
NOTE: The learner describes and demonstrates the head-to-toe assessment by describing appropriate inspection techniques and demonstrating appropriate auscultation and palpation techniques.			
28. Inspect and palpate head for abnormalities			
29. Inspect and palpate face for abnormalities			
30. Inspect and palpate neck for abnormalities	Demonstrate removal AND reapplication of cervical collar for assessment (if indicated)		
31. Inspect and palpate chest for abnormalities			
32. Auscultate breath sounds			
33. Auscultate heart sounds			
34. Inspect the abdomen for abnormalities			
35. Auscultate bowel sounds			
36. Palpate all four quadrants of the abdomen for abnormalities			
37. Inspect and palpate the flanks for abnormalities			
38. Inspect the pelvis for abnormalities			
39. Apply gentle pressure over iliac crests downward and medially			
40. Apply gentle pressure on the symphysis pubis (if iliac crests are stable)			
41. Inspect the perineum for abnormalities			

Skill Steps	Potential Interventions	Demonstrated	
		Yes	No
42. Consider how to measure urinary output	• Assess for contraindications for an indwelling urinary catheter • External catheter • Weighing diapers		
43. Inspect and palpate all four extremities for neurovascular status and abnormalities			
Inspect Posterior Surfaces			
NOTE: If the patient has a suspected spinal or pelvic injury, imaging is obtained PRIOR to turning the patient. The log roll maneuver may cause secondary injuries including spinal injury or hemorrhage. Instructor prompt: "*Imaging has been performed, it is safe to turn the patient*," or "*It is not safe to turn the patient*."			
44. Inspect and palpate posterior surfaces	Not required if suspected spinal or pelvic injury	*	
NOTE: Summarize abnormalities identified, listed below, throughout the scenario. If the learner has not already identified them all, the instructor will ask for any additional noted.			
"What interventions or diagnostics can you anticipate for this patient?"			
45. Identify at least THREE interventions or diagnostics	May include, but not limited to, the following: • Antibiotics • Consults • Head CT for any alterations in mental status • Imaging (other radiographs, CT, US, interventional radiology as indicated) • Law enforcement • Mandatory reporting • Psychosocial support • Social services • Splinting • Tetanus immunization • Wound care		
Just Keep Reevaluating			
"What findings will you continue to reevaluate while the patient is in your care?"			
46. Reevaluate vital signs			
47. Reevaluate all identified abnormalities and effectiveness of interventions			
48. Reevaluate primary survey			
49. Reevaluate pain			
Definitive Care or Transport			
"What is the definitive care for this patient?"			
50. Consider need for admission or transfer to a pediatric-capable facility			
"Is there anything you would like to add?"			

ENPC 6th Edition

Initial Assessment Lecture

SHOCK

This form is to be used during the lecture for your small group assignments

	Shock Categories (There are 4 main categories) #4 has 3 subcategories	Causes	List 1 treatment for each cause
1			
2			
3			
4			

Respiratory Distress vs Failure

This form is to be used during the lecture for your small group assignments

	Respiratory Distress	Severe Distress	Respiratory Failure
Mental Status			
Respiratory Rate			
Work of Breathing			
Heart Rate			
Pulse Ox			
Skin Signs			
Cap Refill			

Pediatric Fever

This form is to be used during the lecture for your small group assignments

Causes of Pediatric Fever	Symptoms	Interventions

Vomiting / Abdominal Pain

This form is to be used during the lecture for your small group assignments

Causes of Vomiting / Abd Pain	Symptoms	Interventions

What Do You Suspect

This form is to be used during the lecture for your small group assignments

1	GI Bleeding	Match #s 1-7 with the signs and symptoms below
2	Gastroenteritis	
3	Hernia	
4	Pyloric Stenosis	
5	Inflammatory Bowel Disease	
6	Peritonitis	
7	Bowel Obstruction	

Signs / Symptoms	What do you suspect Is the cause	Interventions
Hungry infant who vomits after feeding		
Bilious emesis in a young child		
Vomiting / Diarrhea, Hyperactive Bowel Sounds		
Tight/Distended abdomen or rebound tenderness		
Tender masss, may bulge when crying		
Sticky dark stools		
Diarrhea, tenesmus, blood in stool, weight loss		