



Educate **Simplify**
Healthcare Education. Simplified.



PEDIATRIC CARE *and* **WELLNESS**

NCLEX Study Guide



Developmental Milestones of Infant

Age (Months)	Gross Motor	Fine Motor	Language	Social/Cognitive
1	<ul style="list-style-type: none"> Attempts to hold head up when prone 	<ul style="list-style-type: none"> Maintain fistful hands 	<ul style="list-style-type: none"> Cries when upset 	<ul style="list-style-type: none"> Gazes at parent's face when parent speaks
2-3	<ul style="list-style-type: none"> Gains head control when held 	<ul style="list-style-type: none"> Holds rattle when placed in hand 	<ul style="list-style-type: none"> Makes cooing sounds 	<ul style="list-style-type: none"> Smiles in response to smiling & talking
4-5	<ul style="list-style-type: none"> Rolls front to back, then back to front Sits with support 	<ul style="list-style-type: none"> Holds objects with palmar grasp Puts things in mouth 	<ul style="list-style-type: none"> Begins to laugh Makes some consonant sounds 	<ul style="list-style-type: none"> Becomes calmed by parent's voice
6-9	<ul style="list-style-type: none"> Sits without help Begins to crawl May pull to a stand 	<ul style="list-style-type: none"> Moves objects between hands Uses crude pincer to grasp 	<ul style="list-style-type: none"> Babbles & imitates sounds May say "mama" 	<ul style="list-style-type: none"> Recognizes familiar faces May have stranger anxiety
10-12	<ul style="list-style-type: none"> May walk with help or take independent steps Crawls up stairs 	<ul style="list-style-type: none"> Uses 2-finger pincer grasp Hits 2 objects together 	<ul style="list-style-type: none"> Says 3-5 words Uses non-verbal gestures (e.g., waving goodbye) 	<ul style="list-style-type: none"> May have separation anxiety Searches for hidden objects

Children's Belief about Death

Birth to age 2	No understanding of death. Sensitive to loss & separation; may be distressed by changes in the environment, caregivers & regular routines.
Age 3-5	Believes that death is reversible. Thoughts may include magical thinking & fantasy (e.g., they wished that the person would die)
Age 6-9	Understands the concrete finality of death. Difficulty in perceiving their own death; may be preoccupied with the medical or physical aspects of dying.
Age 10-12	Understands that death is final & eventually affects everyone. Thinks about how a death will affect them personally.
Adolescent	Views death on an adult level. Understands that their own death is inevitable but is a difficult concept to perceive; able to think about spiritual & religious aspects of death.

Variations in the Newborn

*All of the following **skin** conditions are normal*



MILIA

- White, pinhead-size, distended sebaceous glands on the nose, cheek, chin, and occasionally on the trunk. Usually disappear after a few weeks of bathing.



EPSTEIN PEARLS

- Palatal cysts of the newborn, which are small white or yellow cystic vesicles.



MONGOLIAN SPOT

- Bluish discoloration in the sacral region of newborn usually seen in African Americans. Carefully document its presence as such action may prevent child abuse charges against parents or caregiver.



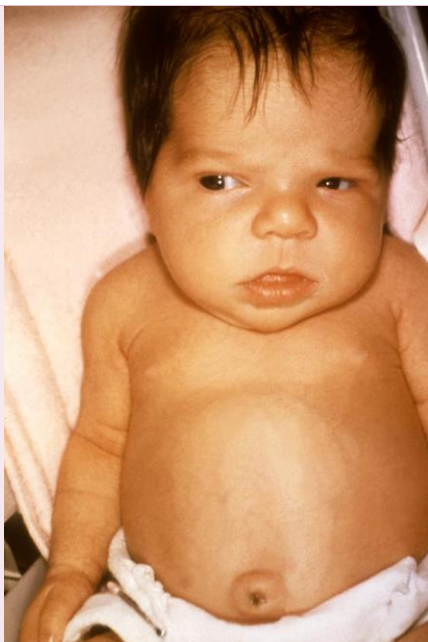
ERYTHEMA TOXICUM NEORATORUM

- Described as flea-bitten lesion ... pink rash with firm, yellow-white papules or pustule on the face, chest, abdomen, back and buttocks of some newborns. Usually appears 24 to 48 hours after birth and disappear in a few days.



HEMANGIOMA

- An abnormal accumulation of blood vessels in the skin of the newborn. It is one of the most common birthmarks associated with childhood and affect 10% of all children.



HYPERBILIRUBINEMIA (Newborn)

- *Physiologic jaundice* is **normal** and appears after 24 hours after birth. And it disappears in about one week.
- *Pathologic jaundice* is seen in the first 24 hours after birth.



VERNIX CASEOSA

- Fatty, whitish secretion of the fetal sebaceous gland to protect the skin from amniotic fluid exposure.



ACROCYANOSIS

- Blue discoloration of the hands and feet in the newborns during the first few days after birth.
- Normal finding and not indicative of poor oxygenation, respiratory distress, or cold stress.



NEVI (Telangiectatic nevi)

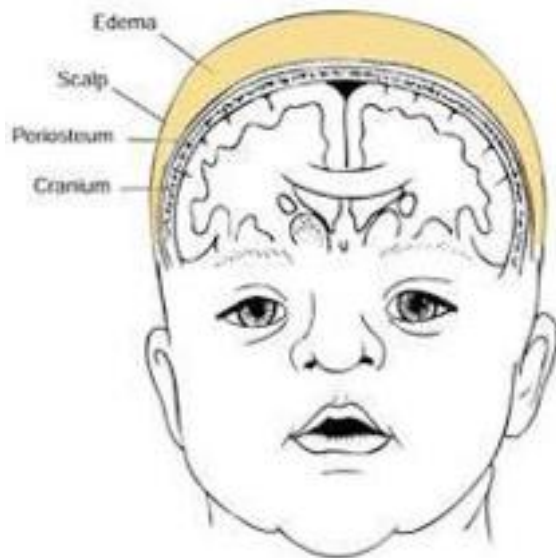
- It also known as "*stork bites*", are pink and easily blanchable skin lesion that appear on upper eyelid, nose, upper lip, lower occipital area, and nape of the neck.
- No clinical significance
- Disappears by 2 years of age



PORT WINE STAIN

- Port-wine stain or nevus flammeus is seen at birth and is composed of a plexus of newly formed capillaries in the papillary layer of the corium
- Commonly found on the face and neck
- Red to purple, varies in size, shape and location
- Does not blanch on pressure

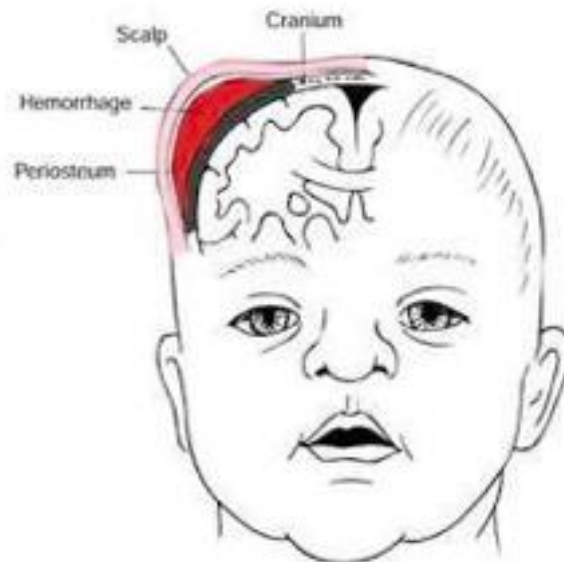
CAPUT SUCCEDANEUM



CAPUT SUCCEDANEUM

- An edema of the scalp of the neonate during birth from mechanical trauma of the initial portion of scalp pushing through a narrowed cervix
- The edema crosses the suture lines
- May involve wide areas of the head or it may just be a size of a large egg
- Caput Succedaneum (CS)—
Crosses Suture line, and Caput Symmetrical

CEPHALOHEMATOMA



CEPHALOHEMATOMA

- A collection of blood between the periosteum of a skull bone and the bone itself.
- Occurs in one or both sides of the head
- Occasionally forms over the occipital bone
- Develops within the first 24 to 48 hours after birth

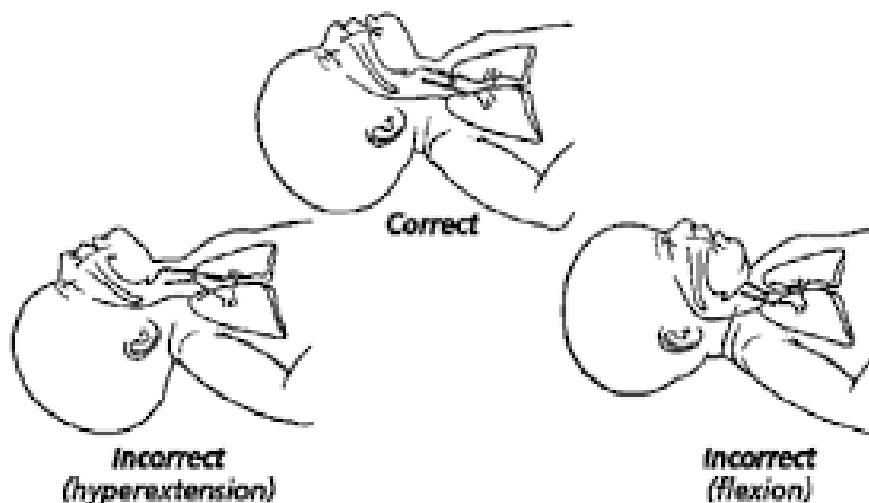
Neonatal Abstinence Syndrome

Pathophysiology	Withdrawal from transplacental opiates due to maternal drug use, typically within 24-48 hours after birth
Clinical Manifestation	Neurologic: Irritability, hypertonia, jittery movements, high-pitched cry, sneezing, diarrhea, vomiting, poor feeding and seizures (rare)
Treatment	Opioid therapy (e.g., morphine, methadone)

Hypersensitivity can make feeding difficult; the newborn should be placed in a side-lying position while swaddled to minimize stimulation and promote nutritive sucking. Between feedings, a pacifier may be used to soothe the infant and help establish an organized sucking pattern.

Excessive movement places the newborn at high risk for skin excoriation; the infant should be **tightly swaddled** with arms flexed to minimize irritation and prevent damage to the skin. Hand mittens and barrier **skin protection** to the knees, elbows, and heels may also be used.

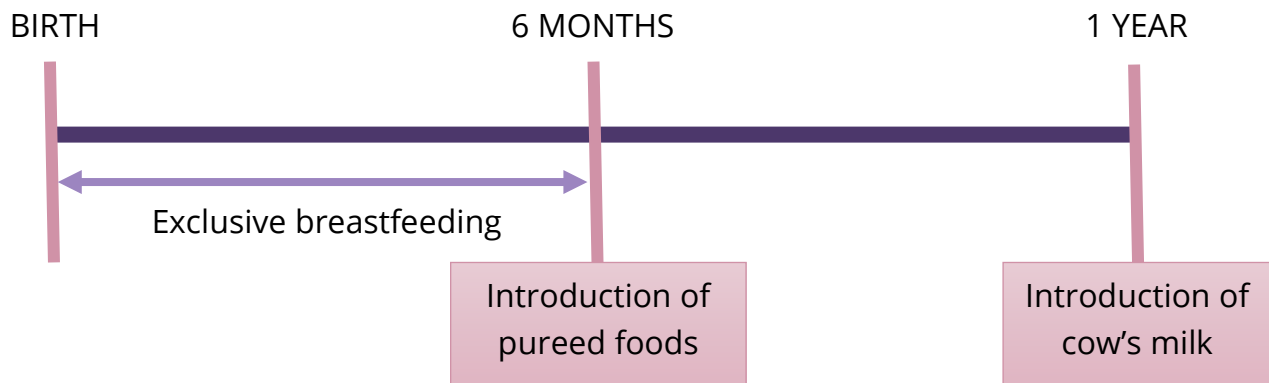
NEONATAL RESUSCITATION



Correct and incorrect head positions for resuscitation

The neonate should be placed on the back with the **neck slightly extended**. This is a **neutral** or "sniffing" position. A **blanket or towel roll** can be placed **under the shoulders**, elevating them 0.75-1.0 in (19-25.4 mm) off the mattress. This is particularly useful if the infant has a large occiput from molding or edema. The nurse must watch that the infant's head does not shift to an improper position during caregiving activities.

Timeline of Infant Nutrition



The introduction of **solid foods** generally occurs at **4-6 months**. The process usually starts with a form of **iron-fortified infant cereal, such as rice or oatmeal**. Cereal can be mixed with breast milk, formula, or water. When introducing new foods, it is important to **allow 5-7 days between foods** to observe for any allergies to a particular food. Allergic responses often worsen with subsequent exposure, so it is a **priority** to identify food triggers as soon as possible.

Infant Formula

- is readily available in 3 forms: **ready-to-feed, concentrated, and powder**. Parents who feed their infants commercial formula should closely follow the manufacturer's recommendations for preparation, particularly if the product requires dilution or reconstitution. Parents should also adhere to basic guidelines for safe storage and handling. Key teaching points include:

- Keep bottles, nipples, caps, and other parts as clean as possible, either by boiling or washing in the dishwasher
- **Wash the tops** of formula cans prior to opening to prevent contamination
- Prepared formula or opened cans of ready-to-feed or concentrated formula should be kept in the refrigerator and **discarded after 48 hours if unused**. There is a risk of bacterial growth after this time.
- Prepared bottles can be warmed by placing in a pan of hot water for several minutes
- Test temperature on the inner wrist before serving to the infant; formula should feel lukewarm, but never hot
- **Never microwave** formula as it can cause mouth burns.

Circumcision

- is performed relatively close to the time of discharge due to the lack of clotting factors at birth and to reduce cold stress.

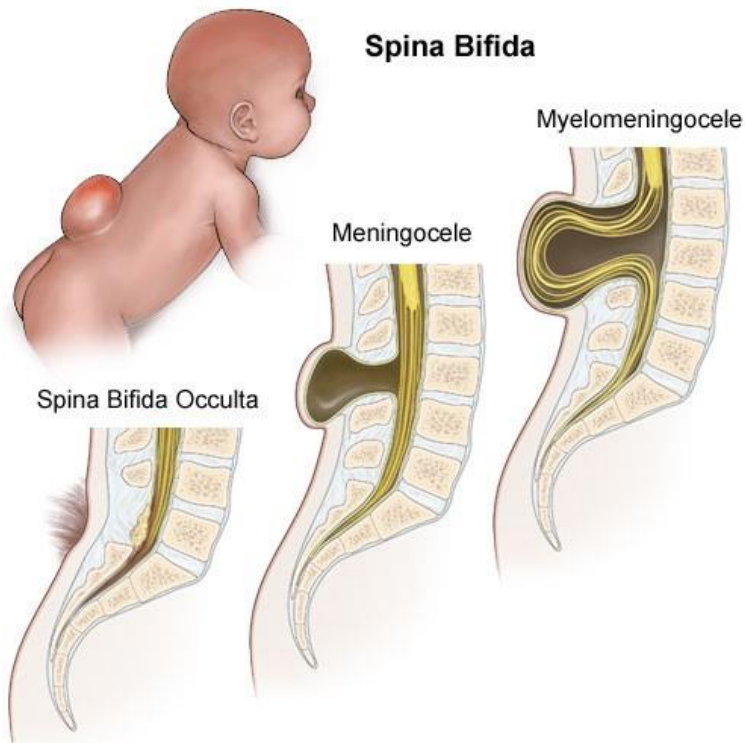
Circumcision care at home includes:

- **Wash hands** before providing care
- Avoid using alcohol-based prepackaged wipes as alcohol prevents healing and causes discomfort. Instead, clean with **warm water** (without soap) every 4 hours to remove urine and feces.
- Apply **petroleum jelly** at diaper changes (unless PlastiBell used); the diaper should be loose over the penis. The diaper should be changed at least every 4 hours to prevent adhesion to the penis.
- Yellow exudate forms as part of the normal healing process after the first 24 hours. It is not a sign of infection and should not be removed forcefully. The exudate will disappear in 2-3 days as healing progresses. Redness, odor, or discharge indicates infection.

Scabies

- - It spread easily via direct skin-to-skin contact. Due to the lengthy incubation period of scabies (30-90 days), all who have been in contact with the infested child must be treated. This involves a one-time application of a scabicide (typically 1% topical permethrin). The child's bedding and clothing should be placed in plastic bags (for a minimum of 3 days) or washed in hot water and dried on the hottest dryer cycle.





- The neural tube develops into the brain and spinal cord. The **Spina bifida** is a defect in which the spinal cord contents can protrude through the vertebrae that did not close. The mildest form is spina bifida occulta, most often at the fifth lumbar or first sacral vertebrae. A **tuft of hair or a hemangioma** may be seen over the site. This is distinguished from lanugo, which is fine downy hair on the back that gradually falls out; a term infant will have minimal lanugo.

- There has been less incidence of spina bifida as there is awareness of the role of **folic acid during pregnancy**. The defect needs surgical repair. Depending on the location of the defect, the child can have bowel and bladder incontinence, hydrocephalus, and sensory loss.

The nurse should report to the HCP for further investigation if any of the following assessment abnormalities occur in a newborn:

- Head circumference <32 cm or >37 cm - a normal head circumference is 32-37 cm. The HCP should assess a neonate with a smaller or larger head circumference.
- Jaundice - this is not a normal finding in a neonate, especially during the first 24 hours and should be investigated further to determine the cause.
- Not voiding in 24 hours - neonates should void and pass meconium within 24 hours after delivery. If they do not, this could indicate a structural anomaly.
- Nasal flaring, chest wall retractions, and grunting with respirations are a sign of respiratory distress.

Valproate (Depakote), a medication used to control seizures, is an FDA pregnancy category D drug that can cause neural tube defects such as spina bifida, but not the distinct facial features of FAS.

Distance visual acuity

- Children age 6 or older is best assessed by asking the child to read letters from the Snellen letter chart using one eye at a time. The child should be able to identify 4 out of 6 letters on the 10/15 line (equivalent to 20/30 vision) with both eyes. In infancy, visual fixation should be present by age 3-4 months and is assessed by following a target.

Bacterial meningitis

- Infants with **bacterial meningitis** can develop **hydrocephalus**. Bulging/tense fontanels and increasing head circumference are important early indicators of increased ICP in children and should be monitored to prevent long-term complications.

Trisomy 18 (Edwards syndrome)

- is a chromosome anomaly characterized by severe cardiac defects and multiple musculoskeletal deformities. Life expectancy for trisomy 18 is a few weeks after birth, neonates rarely survive to their first birthday. End-of-life issues should be discussed early after the diagnosis is confirmed. Trisomy 13 (Patau syndrome) also results in early death.

Trisomy 21 (Down Syndrome)

- is often associated with the cardiac anomaly AV canal defect. Assessment typically includes a loud murmur that requires no immediate action when vital signs are stable. Surgery will correct the anomaly when the neonate grows in size and can tolerate the invasive procedure better.

Fetal alcohol syndrome (FAS)

- is a leading cause of **intellectual disability** and **developmental delay** in the United States. Diagnosis includes history of prenatal exposure to any amount of alcohol, **growth deficiency**, neurological symptoms (eg, microcephaly), or specific facial characteristics (**indistinct philtrum, thin upper lip, epicanthal folds, flat midface, and short palpebral fissures**). Asking about alcohol use during pregnancy can identify newborns and infants who are at risk for FAS. Family support, early intervention, and prevention for subsequent pregnancies are important for families with an infant with this diagnosis.

Cigarette smoking is linked to perinatal loss, sudden infant death syndrome, low birth weight, and prematurity. Specific facial characteristics or syndromes are not typically caused by tobacco exposure in utero

Foreign body

- is an aspiration can be life-threatening. Alkaline battery ingestion can cause corrosive (caustic) damage to the esophagus and intestine and result in perforation. Therefore, batteries must be removed emergently by endoscopy.

Celiac disease

- is an autoimmune disorder in which an individual cannot tolerate **gluten**, a protein found in **barley, rye, oats, and wheat (BROW)**. **Rice, corn, and potatoes** are allowed in the diet and can be used as grain substitutes. Affected individuals must adhere to a gluten-free diet for life.

Pediatric asthma

- it can present as night coughing until the child vomits.

Involuntary bed-wetting

- At night in a child beyond the age of expected bladder control is known as **nocturnal enuresis**. **Primary enuresis** is bed-wetting in children who have never had bladder control. **Secondary enuresis** occurs in a child who has had a previous period of bladder control. **Pharmacologic and nonpharmacologic interventions** can be used in the treatment of enuresis. Parents should be educated on the following therapeutic techniques for nocturnal enuresis:

1. Encourage fluids during the day but restrict after the evening meal
2. Have the child void before going to bed
3. Use **bed alarms** that waken the child when voiding begins
4. Use **positive reinforcement** and **motivation** (eg, a calendar showing wet and dry nights) (**Option 3**)
5. Avoid punishing, scolding, or ridiculing the child
6. Avoid the use of Pull-Ups and diapers at bedtime
7. Have the child assist with wet linen changes but reassure that this is not a punishment (**Option 2**)
8. Awaken the child at a specified time each night to void (**Option 5**)

Intussusception

- (the intestine telescoping into itself) causes intermittent cramping and progressive abdominal pain, inconsolable crying, and **currant jelly stool** (from blood or mucus). **It is often treated successfully with an air enema.**

To measure the urinary output of an infant in diapers, subtract the weight of the diaper when dry from its weight when wet. **One (1) gram of weight is equal to one (1) milliliter of fluid.** Adequate urinary output for an infant is 2 mL/kg/hr.

Calculation:

Urine output in diapers:

Diaper 1: $50 - 30 = 20$ g

Diaper 2: $52 - 30 = 22$ g

Diaper 3: $46 - 30 = 16$ g

Total mg of urine: 58 g = 58 mL

Total output: (Emesis) + (Urine) = 120 mL

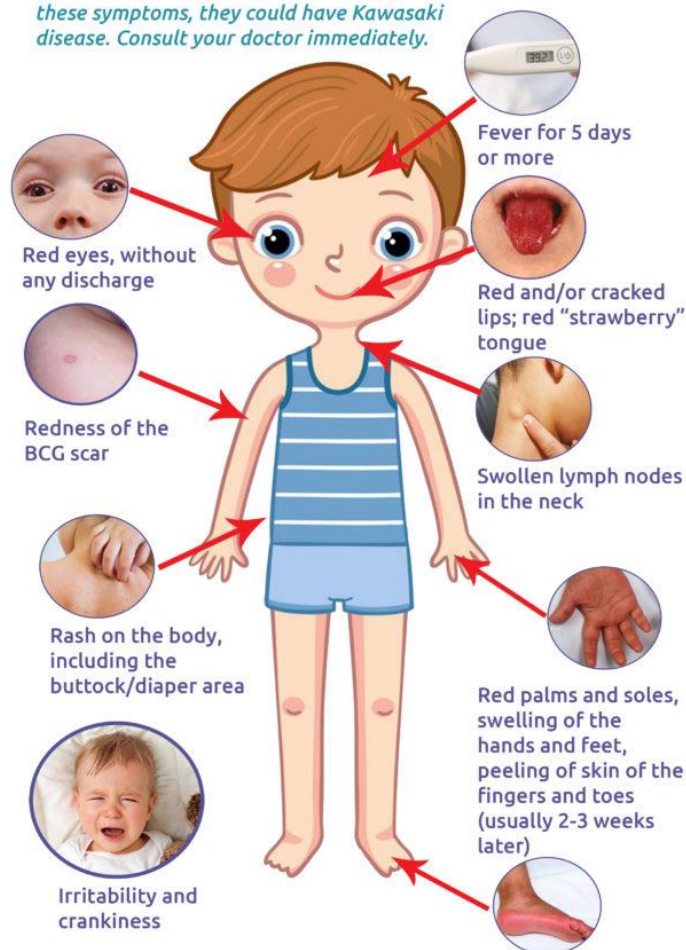
+ 58 mL = 178 mL

Educational objective:

Urinary output for a child in diapers is calculated by subtracting the dry weight of the diaper from its weight when wet. One (1) gram of weight is equal to one (1) milliliter of fluid.

SYMPTOMS OF KAWASAKI DISEASE

If your child has a fever and shows 4 of these symptoms, they could have Kawasaki disease. Consult your doctor immediately.



Kawasaki Disease (KD)

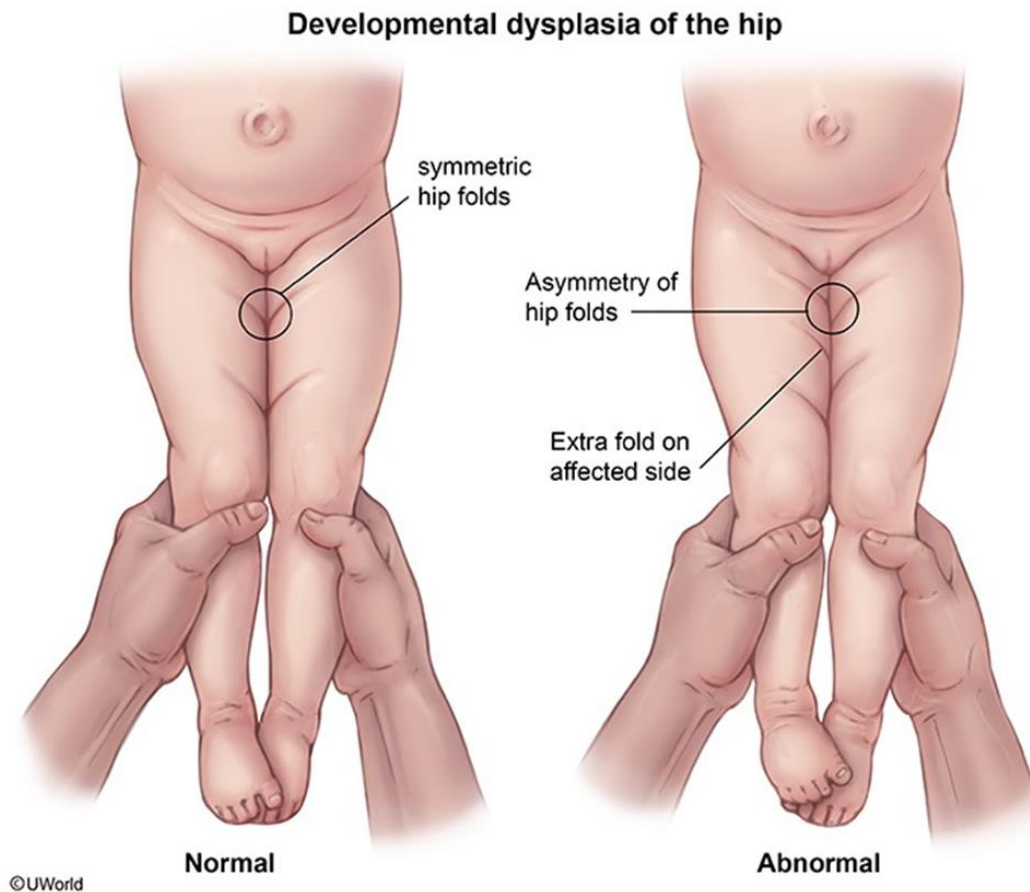
- is a **systemic vasculitis** of childhood that presents with ≥ 5 days of fever, nonexudative conjunctivitis, lymphadenopathy, mucositis, hand and foot swelling, and a rash. First-line treatment consists of **IV immunoglobulin** and **aspirin** to prevent **coronary artery aneurysms**.

When children with KD are discharged home, parents are instructed to **monitor** them for **fever** by checking the temperature (orally or rectally) every 6 hours for the first 48 hours following the last fever. Temperature should also be checked daily until the follow-up appointment. If the child develops a fever, the health care provider should be notified as this may indicate the acute phase of KD recurrence. The child may

require additional treatment with IV immunoglobulin to prevent development of coronary artery aneurysms and occlusions.

IVIg along with aspirin is the recommended initial treatment for Kawasaki disease, with the primary goal of coronary disease prevention.

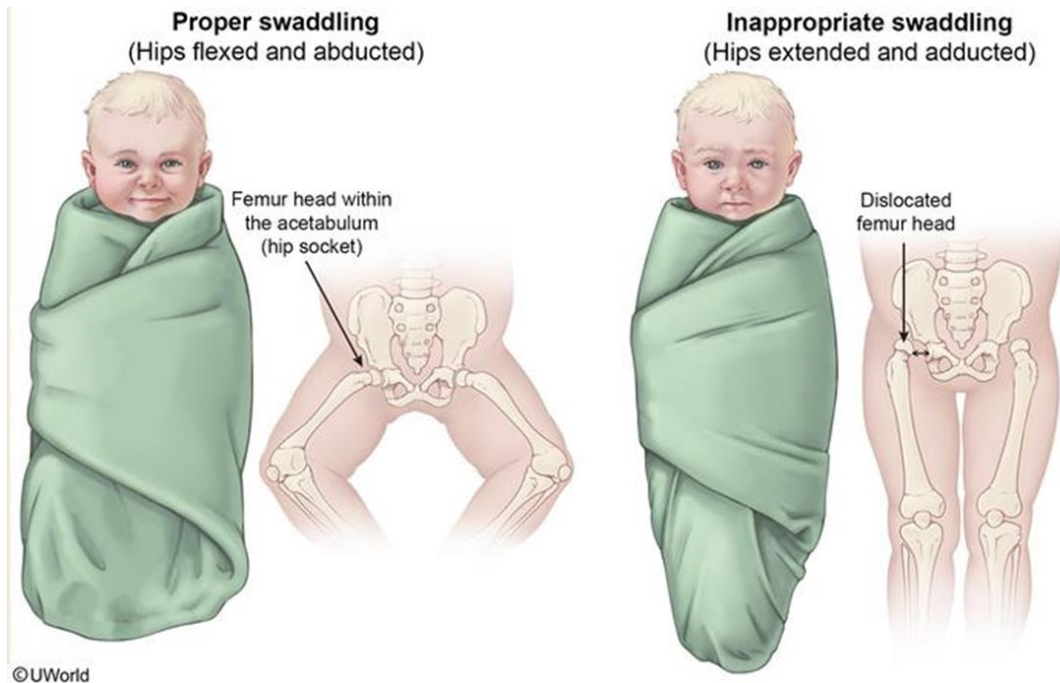
Developmental Dysplasia of the Hip (DDH)



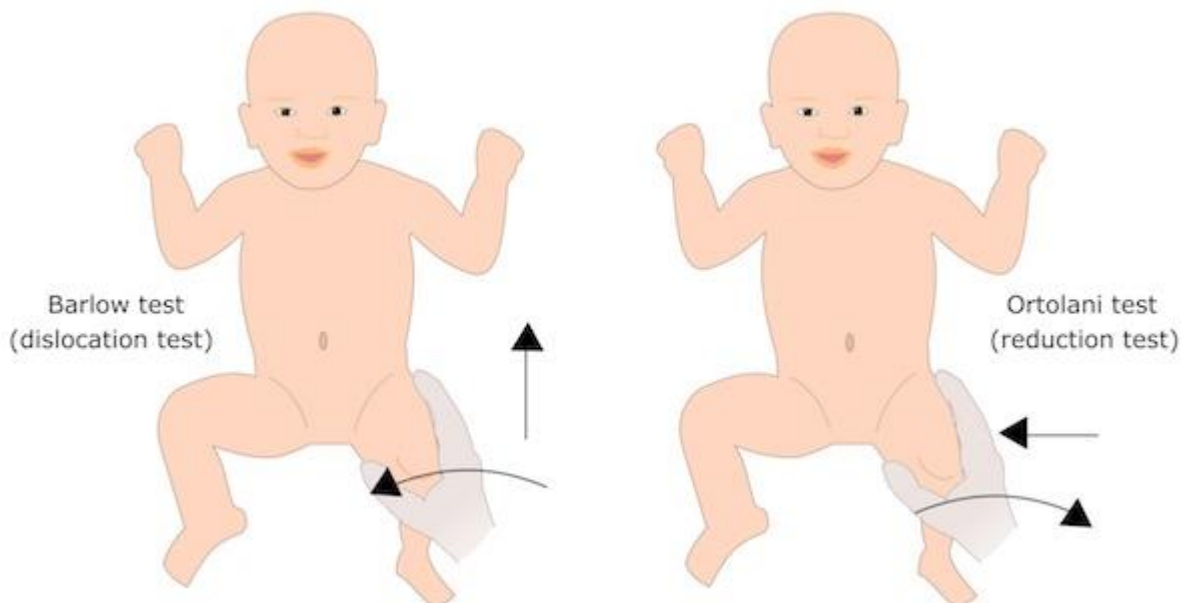
Developmental dysplasia of the hip (DDH) - is a range of various hip abnormalities that may be present at birth or develop during the first few years of life. There are many risk factors, including breech birth, large infant size, and family history. Although all cases cannot be prevented, several interventions have been shown to help reduce the risk of DDH development.

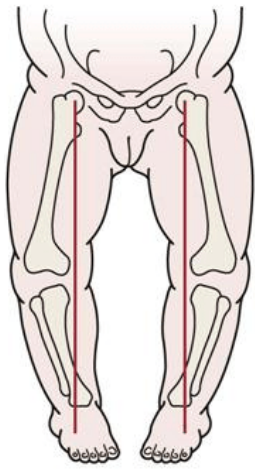
Key measures include:

- **Proper swaddling** technique - infants should be swaddled with their hips bent up (flexion) and out (abduction), allowing room for hip movement (**Option 3**).
- Choosing infant **carriers or** car seats **with wide bases** - infant seats should allow for proper hip positioning in an abducted manner.
- Avoiding any positioning device, seat, or carrier that causes hip extension with the knees straight and together.

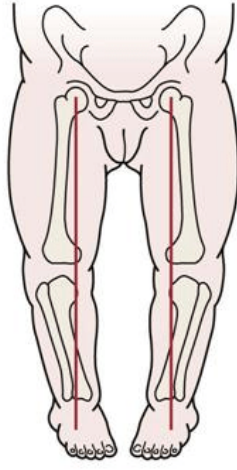


Screening for **developmental dysplasia of the hip** is a standard part of infant assessment. Manifestations in infants age **<2-3 months** include the presence of **extra inguinal or thigh folds** and **laxity of the hip joint** on the affected side. After age 3 months, limited hip abduction and limb shortening on the affected side are evident. A pelvic tilt is noted once the child learns to walk.

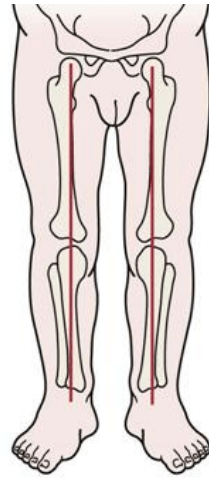




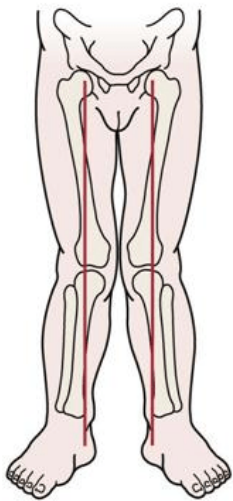
Newborn-
moderate genu varum



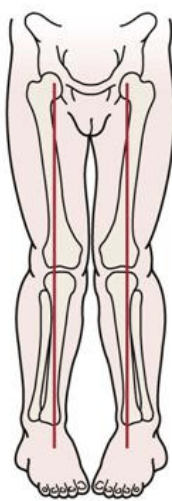
6 months-
minimal genu varum



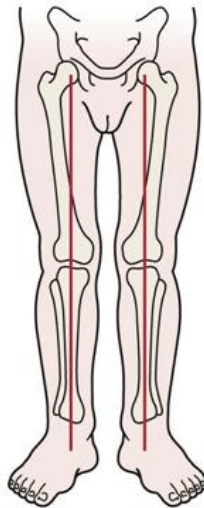
1 year, 7 months-
legs straight



2 years, 6 months-
physiological genu valgum



Protective toeing-in



4 to 6 years-
legs straight with normal
toeing-out



Pavlik harness



Shaken baby syndrome

- is a form of child physical abuse resulting from violent shaking of an infant by the extremities or shoulder that causes bleeding within the brain and/or eyes. The clinical findings of shaken baby syndrome are nonspecific and include lethargy, vomiting, seizures, irritability, inability to eat, and inconsolable crying. Multiple and severe shaking episodes can result in breathing difficulty and lifelessness. Caregivers typically do not report a history of trauma.

Hypospadias

-a condition in which the urethral opening is on the underside of the penis, is surgically corrected by rerouting the urethra and inserting a temporary stent to aid healing. **Urinary output** is closely monitored postoperatively to ensure patency.

Hemophilia

- is a hereditary bleeding disorder caused by a deficiency in coagulation proteins, increasing the risk for bleeding. Clients with hemophilia who are injured should be monitored closely for bleeding (eg, intracranial bleeds, bleeding into joints). Signs of an intracranial bleed include lethargy, headache, irritability, and vomiting. An intracranial bleed is lethal if unchecked, so administration of **factor VIII to a client with hemophilia A** is the first order of action, followed by a CT scan. The nurse should avoid procedures that can cause bleeding (eg, intramuscular injections, rectal temperature measurement). Vaccinations are administered **subcutaneously** whenever possible to prevent intramuscular hematoma (**Option 2**). The smallest gauge needle is used, and firm, continuous pressure is applied at the site for 5 minutes

Treatment consists of replacing the missing clotting factor and teaching the client about injury prevention, including:

- Avoid medications such as ibuprofen and aspirin that have platelet inhibition properties (**Option 4**).
- Avoid intramuscular injections; subcutaneous injections are preferred.
- Avoid contact sports and safety hazards; **noncontact activities** (eg, swimming, jogging, tennis) and use of protective equipment (eg, helmets, padding) are encouraged (**Option 5**).
- Dental hygiene is necessary to prevent gum bleeding, and soft toothbrushes should be used.
- **MedicAlert bracelets** should be worn at all times (**Option 3**).
- Clients with hemophilia are at risk for **permanent joint destruction** due to frequent bleeds into the joint spaces. Assisting clients with decreasing

the incidence of bleeding episodes and prompt treatment when bleeding occurs can help minimize joint destruction.

- **(Option 1)** Fantasy play with puppets is more appropriate for a preschool-age child as imaginary play and magical thinking peak during this stage of development.
- **(Option 2)** Although school-age children enjoy spending time with friends, peer relationships are significantly more important during the adolescent period.
- **(Option 4)** Watching television is a good diversion for all hospitalized children, but it does not promote age-specific growth and development.

Educational objective:

According to Erikson's stages of psychosocial development, school-age children deal with the conflict of industry versus inferiority. During this stage, unlike other developmental stages, learning is a priority and completing school work provides a sense of accomplishment and satisfaction. It is therefore important that parents provide hospitalized school-age children with missed school work on a regular basis.

Infant Botulism

- Although more than one of these parent comments are concerning, the most concerning is feeding honey to a child under age 1 year. **Honey** (especially raw or wild) is **not** recommended for children **under age 1** due to the risk for **infant botulism**. An infant under age 1 has an immature gut system that can allow *Clostridium botulinum* spores contaminated in honey to colonize the gastrointestinal tract and release toxin that causes botulism.

Botulinum toxin produces muscle paralysis by inhibiting the release of acetylcholine at the neuromuscular junction. Infants often present with **constipation**, diminished deep tendon reflexes, and generalized weakness. Additional symptoms are lack of head control, difficulty in feeding, and decreased gag reflex, which can progress to **respiratory failure**. Isolation of the organism from the child's stool can take several days; therefore, diagnosis is usually made by history, and treatment with botulism immune globulin is started before laboratory results are known.

Symptoms of infant botulism include **constipation, generalized weakness, difficulty feeding, and diminished deep-tendon reflexes**. This condition is a high priority due to the risk of respiratory failure. **HONEY MIEL EN MENORES DE 1 AÑO.**

Chicken Pox

- transmitted primarily by **airborne spread of secretions** from the nasopharyngeal secretions of an infected individual and through direct contact of open lesions. It is most **contagious** 1–2 days before the rash until shortly after onset of rash (**until all lesions are crusted over**). Supportive care is usually adequate, and most children recover fully. Children who are immunocompromised are at risk for complications. Contact and airborne precautions are used. A mask will help prevent the spread of infection until the child is placed in an **isolation negative airflow room**.

This child has chicken pox (varicella), given the vesicular lesions.



Tetralogy of Fallot

- is a congenital cardiac defect that typically has 4 characteristics: pulmonary stenosis, right ventricular hypertrophy, overriding aorta, and ventricular septal defect.

This infant is experiencing a **hypercyanotic episode, or "tet spell,"** which is an exacerbation of tetralogy of Fallot that can happen when a **child cries, becomes upset, or is feeding**. The child should first be placed in a **knee-to-chest position**. Flexion of the legs provides relief of dyspnea as this angle improves oxygenation by reducing the volume of blood that is shunted through the overriding aorta and the ventricular septal defect.

Autism spectrum disorder (ASD)

- ASD is a complex neurodevelopmental disorder characterized by the onset of abnormal functioning before age 3. The 2 core symptoms of ASD are abnormalities in **social interactions** and **communication** (verbal and

nonverbal), and **patterns of behavior**, interests, or activities that can be **restricted and repetitive**. Social skills, especially communication, are delayed more significantly than other developmental functioning and are the focus during client assessment.

The vast majority of children diagnosed with ASD lack the acquisition of communication skills during the first 2 years of life. A healthy 2-year-old should have a vocabulary of about 300 words and should be able to string 2 or more words together in a meaningful phrase. Assessing this child's language abilities would be the priority.

The concerns presented by this child's parent are suggestive of a developmental delay and very possibly **autism spectrum disorder (ASD)**.

Fifth disease

- ("slapped face," or erythema infectiosum) is a viral illness caused by the human parvovirus and affects mainly school-age children. The virus spreads via respiratory secretions, and the period of communicability occurs before onset of symptoms. The child will have a distinctive red rash on the cheeks that gives the appearance of having been slapped. The rash spreads to the extremities and a maculopapular rash develops, which then progresses from the proximal to distal surfaces. The child may have general malaise and joint pain that are typically well controlled with nonsteroidal anti-inflammatory drugs such as ibuprofen. Affected children typically recover quickly, within 7-10 days.

Parvovirus B-19 is a common childhood infection also known as "**fifth disease**." Infected clients display a characteristic "slapped cheek" rash on the face. Symptoms range in severity; however, most children do not require intervention. Transmission of the infection is usually through person-to-person contact, especially with respiratory secretions.

Although rare, infection with parvovirus B-19 during pregnancy can cause fetal anomalies (eg, hydrops fetalis, stillbirth). It is recognized as a **TORCH infection** (**T**oxoplasmosis, **O**ther [parvo-B19/varicella zoster], **R**ubella, **C**ytomegalovirus, **H**erpes simplex virus), a group of infections that cause **fetal abnormalities**. Delegation of this client to a pregnant nurse is inappropriate due to potential harm to the fetus.

Once these children develop symptoms (eg, rash, joint pains), they are no longer infectious. **Isolation** is **not** usually **required** unless the child is hospitalized with aplastic crisis or immunocompromising condition.

A potentially **fatal complication** is Hirschsprung **enterocolitis**, an inflammation of the colon, which can lead to sepsis and death. Enterocolitis will present with **fever**; lethargy; **explosive, foul-smelling diarrhea**; and **rapidly worsening abdominal distension**.

Signs & Symptoms of Heart Failure

Impaired myocardial contractility	<ul style="list-style-type: none">• Tachycardia• Pale, cool extremities• Weak peripheral pulses• Decreased blood pressure• Decreased urinary output• Activity intolerance, weakness/fatigue• Loss of appetite
Pulmonary congestion	<ul style="list-style-type: none">• Dyspnea• Tachypnea• Orthopnea
Systemic venous congestion	<ul style="list-style-type: none">• Hepatomegaly• Peripheral edema (periorbital in children)• Neck vein distension• Weight gain ascites

Weak lower and strong upper extremity pulses are present in **coarctation of the aorta**.

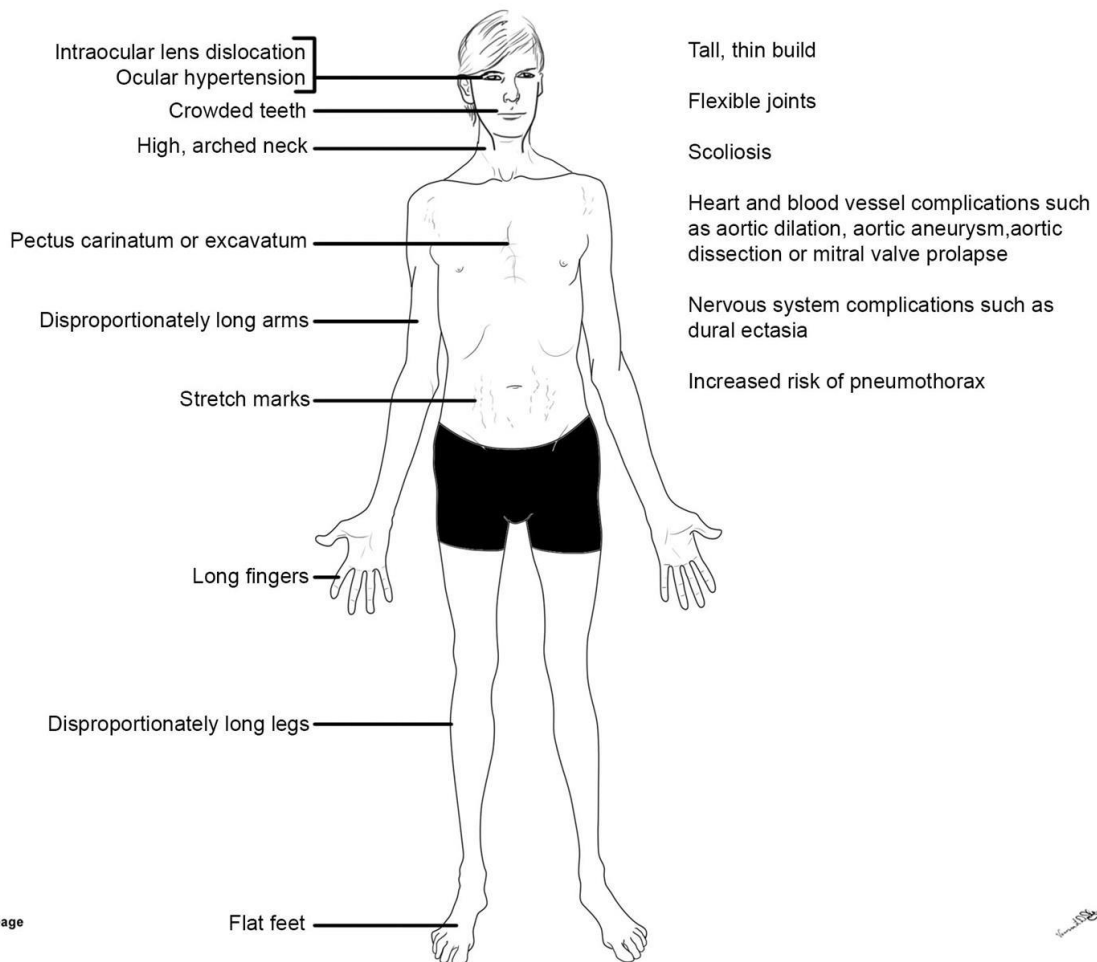
In a child with **atrial septal defect**, the nurse would expect to hear a heart **murmur** on auscultation of heart sounds.

Weight gain slows during the toddler years with an average yearly weight gain of 4-6 lb (1.8-2.7 kg). By age 30 months, current weight should be approximately 4 times greater than birth weight. A toddler weighing 6 times the initial birth weight requires further evaluation. Family nutrition and meal habits should be discussed.

Bronchiolitis

- it is a common viral illness of childhood that is usually caused by RSV. The focus of home care is on monitoring respiratory status and periodic **nasal suctioning using saline nose** drops to ease breathing. Additional fluids should be offered.

Marfan Syndrome



Marfan Syndrome

- is an **autosomal dominant** disorder affecting the connective tissues of the body. Abnormalities are mainly seen in the cardiovascular, musculoskeletal, and ocular systems. Clients with Marfan syndrome are very **tall and thin**, with disproportionately long arms, legs, and fingers.

Cardiovascular manifestations of Marfan syndrome include **abnormalities of the aorta** and **cardiac valves**, including **aneurysms, tears (dissection), and leaky heart valves** that may require replacement or repair. Therefore, competitive or **contact sports are discouraged** due to the risk of cardiac injury and sudden death.

Microcephaly

- is an effect of fetal alcohol syndrome or cytomegalovirus infection.

Craniofacial defects

- Craniofacial defects, including cleft lip and palate (eg, congenital anomalies), can be caused by maternal anticonvulsant use (eg, valproic acid).

Meconium ileus

- is classic for cystic fibrosis, a genetic disorder.

Floppy muscle tone

- is a typical for Down's syndrome, a genetic disorder.

The normal range for hemoglobin in a 1-month-old is 12.5-20.5 g/dL (125-205 g/L). Hemoglobin of 24.9 g/dL (249 g/L) is diagnostic of **polycythemia** (elevated hemoglobin levels). Infants with cyanotic cardiac defects can develop polycythemia as a compensatory mechanism due to prolonged tissue **hypoxia**. Polycythemia will increase blood viscosity, placing an infant at risk for **stroke** or thromboembolism. Clubbing is another manifestation of prolonged hypoxia.

The ductus arteriosus of a newborn should close spontaneously when fetal circulation changes to pulmonary circulation. If the ductus arteriosus remains open, blood will shunt from the aorta to the pulmonary arteries. The child will be acyanotic but will have a machine-like murmur heard on both systole and diastole.

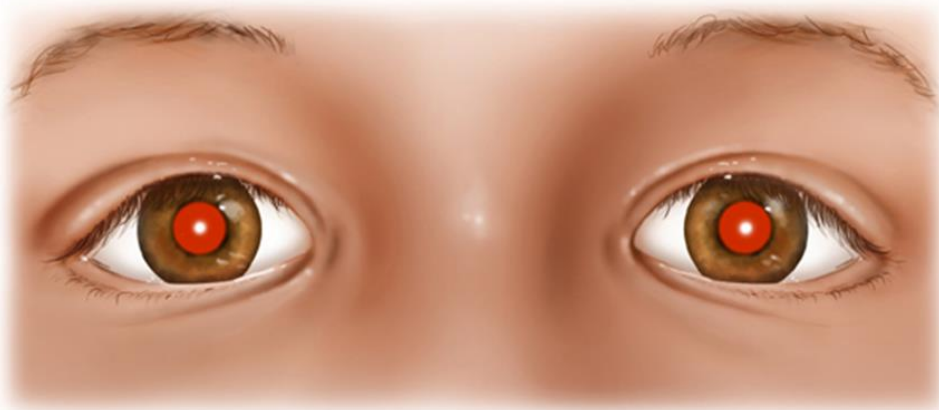
Established family patterns that can play a role in recurrent OM should be assessed and include:

- Recurring **exposure to tobacco smoke**
- **Regular pacifier use**, particularly after age 6 months
- **Drinking from a bottle** while lying down
- **Lack of immunizations**, particularly the pneumococcal vaccine series

Pyloric stenosis

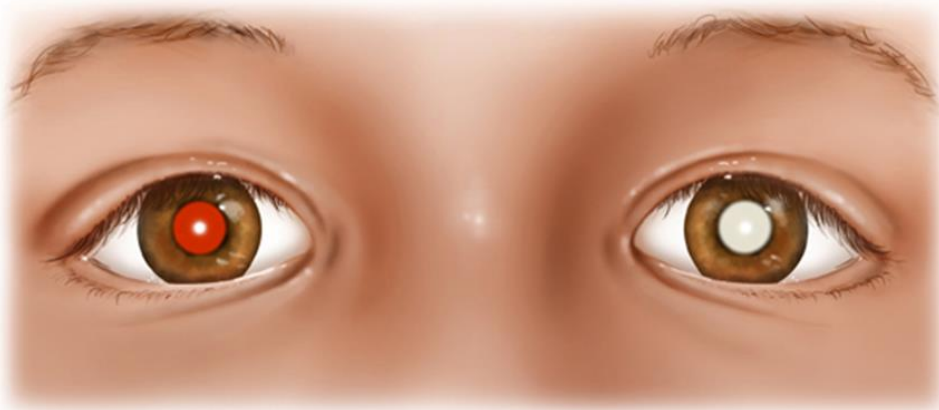
- In **pyloric stenosis**, a hypertrophied pyloric muscle causes postprandial projectile vomiting secondary to an obstruction at the gastric outlet. An **olive-shaped mass** may be palpated in the epigastric area just to the right of the umbilicus. Emesis is **nonbilious** (formula in/formula out) and leads to progressive dehydration. Infants will be **hungry constantly** despite regular feedings. A hematocrit of 57% (0.57) is elevated and indicative of **hemoconcentration** caused by **dehydration (Option 2)**. Elevated blood urea nitrogen is also a sign of dehydration.

Normal eyes & white reflex



Normal eyes

Red reflexes & corneal light reflexes are equal



Absent reflex

White reflex on abnormal eye can result from opacities of the lens (eg, cataract), or tumor (eg, retinoblastoma)

©UWorld

Retinoblastoma- a unilateral or bilateral retinal tumor, is the most common childhood intraocular **malignancy**. It is typically diagnosed in children under age 2 and is usually first recognized when parents report a **white "glow" of the pupil** (leukocoria). Light reflecting off the tumor will cause the pupil to appear white instead of displaying the usual red reflex (**Option 1**). Parents may even accidentally visualize leukocoria when taking a photograph of the child using a flash. **Strabismus** (misalignment of the eyes) is the second most common sign; visual impairment is a late sign indicative of advanced disease.

The treatment depends on severity and may include *radiation therapy* or *enucleation (removal of the eye) and fitting for prosthesis*. **Siblings** should undergo regular **ocular screening**, as some forms of retinoblastoma are **hereditary**.

FTT (Failure to Thrive)

- is generally defined as weight less than 80% of ideal for age and/or depressed weight for length, correcting for gestational age, sex, and special medical conditions. The underlying *cause of FTT is inadequate dietary intake; contributing factors include a disturbance in feeding behavior and psychosocial factors.*

Observing the child feeding or when hungry will provide the nurse the opportunity to identify potential factors contributing to insufficient intake. The nurse can observe the type of food being offered, the quantity of food consumed, how the child is held or positioned while being fed, the amount of time for feeding, the parent's response to the child's cues, the tone of the feeding, and the interaction between the child and the parent.

FTT, or growth failure, is a state of undernutrition and inadequate growth in infants and young children. Most cases of FTT are related to an inadequate intake of calories, which can be tied to many different etiologies. Physiologic risk factors for FTT include preterm birth, breastfeeding difficulties, **gastroesophageal reflux**, and **cleft palate**.

Socioeconomic risk factors include:

- Poverty – most common
- Social or emotional isolation – parents may lack the support system needed to assist them with the problems of child rearing
- Cognitive disability or mental health disorder
- Lack of nutritional education – parents may not have knowledge of proper feeding techniques or appropriate calorie intake based on age and size of the child

Clinical manifestations of **acyanotic defects** may include:

- Tachypnea
- Tachycardia, even at rest
- Diaphoresis during feeding or exertion
- Heart murmur or extra heart sounds
- Signs of congestive heart failure
- Increased metabolic rate with poor weight gain

A gluten-free diet is required for clients with celiac disease who cannot tolerate **barley**, **rye**, **oats**, or **wheat** (mnemonic: **BROW**). Low-phosphate diets are indicated for clients with certain kidney disorders. Low-sodium diets are indicated for volume overload states (eg, heart failure, ascites) and hypertension.

A **marked decrease** in respiratory rate or **increased work of breathing** may indicate respiratory fatigue, and immediate intervention is needed. Impending **respiratory failure** is the immediate priority.

FTT in a child is characterized by a low weight/height ratio and/or falling below the 5th percentile on the growth curve due to inadequate caloric intake, inadequate absorption of calories, or excess caloric expenditure. Most children with a diagnosis of FTT have inadequate caloric intake caused by multiple behavioral or psychosocial factors, including disturbances in child-parent interaction.

Risk factors for FTT include:

- Young parent age
- Unplanned or unwanted pregnancy
- Lower levels of parental education
- Single-parent home
- Social isolation
- Chronic life stresses/anxiety in the home
- Disordered feeding techniques
 - Prolonged breast or bottle feeding
 - Unstructured meal times
 - Negative or difficult interactions at meal time
 - Poor parental feeding skills
 - Negative attitudes toward food – fear of obesity or an overweight child
- Substance abuse
- Domestic violence and/or parental history of child abuse
- Poverty, food insecurity
- Parents who have a negative perception of the child

Slow Growth pattern

- A child who demonstrates a slow growth pattern will undergo diagnostic evaluation to determine the cause. If the cause is found to be growth hormone deficiency, the child may undergo **growth hormone replacement** therapy. The biosynthetic hormone is administered via subcutaneous injection on a daily basis. Despite replacement therapy, the child may still have a **final height less than "normal."** Treatment is most successful when diagnosis and replacement therapy **begin early in the child's life.** When to stop therapy is decided by the client, family, and provider. However, growth less than 1 inch (2.5 cm) per year and bone age of 14 years in girls and 16 years in boys are the criteria often used to stop therapy.

Important Respiratory Tract Infections in Children

Clinical Illness	Presentation	Common Etiologic Agents
Nasopharyngitis (common cold)	Nasal congestion & discharge, sneezing, cough & sore throat	<ul style="list-style-type: none"> • Rhinovirus • Influenza • Coronavirus
Laryngotracheitis (croup)	Upper respiratory tract symptoms followed by hoarseness, barking cough, stridor & respiratory distress	<ul style="list-style-type: none"> • Parainfluenza virus
Epiglottitis	Sore throat, dysphagia, drooling & respiratory distress; sitting up & leaning forward	<ul style="list-style-type: none"> • <i>Haemophilus influenzae</i>
Bronchiolitis	Upper respiratory tract symptoms followed by wheezing, cough, stridor & respiratory distress	<ul style="list-style-type: none"> • Respiratory syncytial virus

- Epiglottitis (supraglottitis), a sudden-onset **medical emergency** due to *Haemophilus influenzae*, causes severe inflammatory obstruction above and around the glottis. The affected child will typically progress from having no symptoms to having a completely occluded airway within hours. Sitting in a **tripod position** (upright and leaning forward with the chin and tongue sticking out) is a classic presentation. The child will likely **drool** and be very **restless** and **anxious** secondary to airway obstruction and hypoxia. **Throat inspection** should **not** be done until emergency intubation is readily available (if necessary).
- Epiglottitis should be considered first in a 3-7-year-old child with acute respiratory distress, toxic appearance (eg, sitting up, leaning forward, **drooling**), stridor, and high-grade fever. Tachycardia and tachypnea are also present. This is a pediatric **emergency** and should be managed with endotracheal **intubation**; however, intubation of such clients is difficult, and preparation for possible tracheostomy is also standard. The complications of epiglottitis are serious and include sudden airway obstruction.

Premature

- an infants require **iron supplementation** by age **2-3 months**, which is when maternal iron stores are depleted. Appropriate sources include oral iron drops if breastfeeding or iron-fortified formula.

The priority nursing action when providing oxygen therapy and monitoring oxygen saturation is to verify the accuracy of the saturation reading. Additional actions may then be taken, which may involve auscultating the child's lungs. Interventions to improve oxygenation include increasing the rate of oxygen flow and having the child sit in full Fowler's position and take slow, deep breaths.

Hearing Impairment

- an infants delay development of intelligible speech. As these infants become toddlers, they often have a loud voice and monotone speech that is difficult to understand. They appear shy, timid, and **inattentive**.

Chronic Allergic Rhinitis

- prevention of symptoms plays an important role in the management of chronic allergic rhinitis. Preventive measures to reduce exposure include using hypoallergenic pillow and mattress covers, eliminating carpet in the home, keeping windows closed, installing high-efficiency air filters, regularly mopping hard floors, and frequently damp-dusting furniture.

Common applications of droplet precautions	Personal protective equipment
<ul style="list-style-type: none">• <i>Neisseria meningitidis</i>• <i>Haemophilus influenzae</i> (type B)• Diphtheria• Mumps• Rubella• Pertussis• <i>Streptococcus</i> group A (strep throat)• Viral Influenza	<ul style="list-style-type: none">• Surgical Mask• Private room• As needed for procedures with risk of splash or body fluid contact: Nitrile gloves, disposable gown, goggles/shield

Pertussis

- (whooping cough) is a very **contagious** communicable disease caused by the *Bordetella pertussis* bacteria. These organisms attach to the small hairs in the airway and release a toxin that causes swelling and irritation. Pertussis is spread from person to person by coughing, sneezing, and close contact. As a result, an affected client should be placed in standard (universal) and droplet isolation precautions when hospitalized.

At first, symptoms similar to the common cold and a mild fever occur, but eventually these clients develop a characteristic **violent, spasmodic cough**. Coughing is so severe that the person is forced to inhale afterward, resulting in a distinctive, high-pitched "whooping" sound. Coughing episodes may continue until a **thick mucus plug** is expectorated and are sometimes followed by vomiting (**post tussive emesis**). **Vaccination** against whooping cough is available, but some individuals will still develop the disease, although in a milder form.

The treatment consists of *antibiotics and supportive measures*. **Humidified oxygen** and **adequate fluids** will help loosen the thick mucus. Suction as needed is important in infants. Respiratory status should be monitored for obstruction. The client should be positioned on the left side to prevent aspiration if vomiting occurs.

Before initiating a treatment program that requires a client and family to make major lifestyle and behavior changes, the nurse needs to assess readiness for change. Motivation and a desire for change are the keys to successful weight loss.

Tooth avulsion

- At age 15, clients should have their permanent teeth. **If tooth avulsion** occurs, there is limited time (**≤1 hour, longer if placed in cold milk**) until death of the tooth. This is a time-sensitive condition and the client should be seen first to avoid loss of a permanent tooth.

Status Epilepticus

- This is a serious and life-threatening emergency in which a client has been seizing for **5 minutes or longer**. **Grunting** and a **dazed appearance** are 2 common signs. A client with hydrocephalus (abnormal collection of cerebrospinal fluid in the head) and a **ventriculoperitoneal (VP) shunt** is at a higher risk for **seizures**. Stopping seizure activity is the first nursing priority. **IV benzodiazepines (diazepam or lorazepam)** are used **acutely** to control seizures. However, rectal diazepam is often prescribed when the IV form is unavailable or problematic. Parents often get prescriptions for rectal diazepam and are advised to administer a dose before bringing a child to the emergency department.

Absence seizures

- occur in children age 4-12 and usually disappear at puberty. Clinical manifestations include a **brief loss of consciousness** and an appearance of **inattention** or **daydreaming** (the absence attack) without loss of postural body tone. However, slight loss of tone may lead to **dropping objects** held in hands. Most absence seizures last **less than 10 seconds** and often go unrecognized. Following an attack, behavior and awareness return immediately to normal. The child does not experience a postictal period but usually has no recollection that a seizure has occurred. A child may have **multiple** absence seizures each day. Treatment includes the use of anticonvulsant medication(s).

SEE STARE (MIRA FIJAMENTE)

Acute Diarrhea

During bouts of **acute diarrhea** and dehydration, treatment focuses on maintaining adequate fluid and electrolyte balance. The first-line treatment is **oral rehydration therapy**, using oral rehydration solutions (ORSs) to increase reabsorption of water and sodium. Even if the diarrhea is accompanied by vomiting, ORS should still be offered in small amounts at frequent intervals. Continuing the child's **normal diet** (solid foods) is encouraged as it shortens the duration and severity of the diarrhea. **The BRAT** (bananas, rice, applesauce, and toast) **diet is not recommended as it does not provide sufficient protein or energy.**

Hemolytic uremic syndrome (HUS)

- is a life-threatening complication of ***Escherichia coli* diarrhea** and results in red cell hemolysis, low platelets, and acute kidney injury. Hemolysis results in anemia, and low platelets manifest as **petechiae or purpura**. Therefore, the presence of petechiae in this client could indicate underlying HUS and needs further assessment.

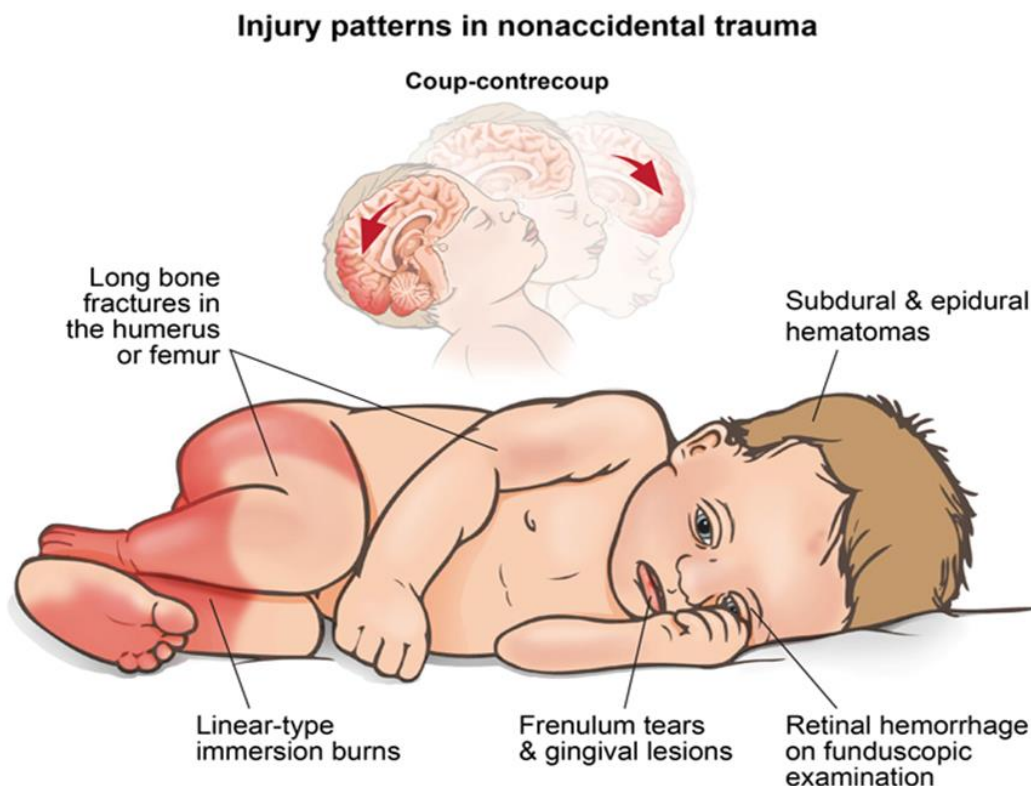
Peritonsillar or retropharyngeal abscess

- is a serious complication that can result from tonsillitis or pharyngitis. **A "hot potato" or muffled voice, trismus (inability to open the mouth), pooling of saliva, and deviation of the uvula to one side** are the presenting features. Maintaining an adequate airway is essential.

Sickle cell crisis

Management of sickle cell crisis focuses on the following:

1. **Pain control** with narcotics - analgesics are provided **around the clock or with patient-controlled analgesia**, rather than as needed, to prevent breakthrough pain. Clients with SCD often need large doses of **narcotics**.
2. **Hydration** - aggressive intravenous and oral hydration is recommended (to reduce the viscosity of the blood)
3. **Oxygenation** - to prevent pulmonary complications and provide comfort
4. **Infection prevention** - age-appropriate vaccination plus pneumococcal, influenza, and meningococcal vaccination
5. **Diet** - the client is encouraged to have a **high-protein, high-calorie diet** with folic acid and a multivitamin **without iron**
6. **Folic acid** - given to help in the creation of the new red blood cells needed due to the hemolysis.



Children age <10 should automatically be upgraded to 1 level higher than the triaged urgency of their medical issues. The combination of status asthmaticus and an oxygen saturation $\leq 92\%$ qualifies for the highest priority level of triage at any age.

“**Nonmaleficence** is doing no harm, **fidelity** is loyalty and commitment, **justice** is equal treatment for all, **beneficence** is doing good for the client's best interest, and **autonomy** is making decisions for oneself.”

Phenylketonuria (PKU)

is a genetic inborn error of metabolism. Individuals with PKU lack the required enzyme (phenylalanine hydroxylase) for converting the amino acid phenylalanine into the amino acid tyrosine. As unconverted phenylalanine builds up, irreversible neurologic damage can occur.

A **low-phenylalanine diet** is the only treatment for PKU. Phenylalanine cannot be totally eliminated from the diet as it is an **essential amino acid** and necessary for normal development. The diet must meet nutritional needs while maintaining phenylalanine levels within a **safe range** (2-6 mg/dL for clients under age 12). There is no known age at which the diet can be discontinued safely, and **lifetime dietary restrictions** are recommended for optimum health

Dietary management of the client with PKU includes:

1. **Monitoring serum levels** of phenylalanine
2. Including **synthetic proteins** and **special formulas** (eg, Lofenalac, Phenyl-Free) in the diet
3. **Eliminating** high-protein/phenylalanine foods (eg, **meats, eggs, milk**) from the diet
4. Encouraging consumption of **natural foods** low in phenylalanine (**most fruits and vegetables**)

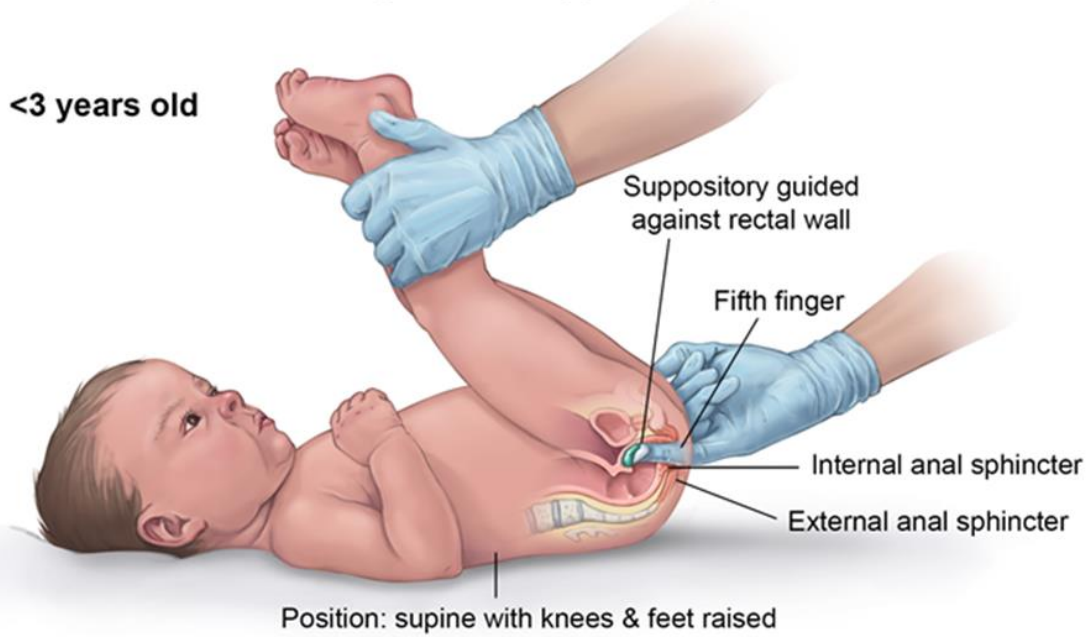
Key instructions for safe, effective administration of oral iron supplements include:

- **Administer between meals** - Concentrations of stomach acid is higher between meals, breaking down the iron to an easily absorbed state
- **Give with citrus juice** - Absorption is enhanced when taken with a good source of vitamin C, such as orange juice or other citrus fruit
- Place medicine at the **back of the mouth** - Liquid iron can cause temporary staining of the teeth.
- **Avoid giving with milk** - Milk and other products with high amounts of calcium reduce adequate absorption of iron supplements
- Keep **no more than a 1-month supply**

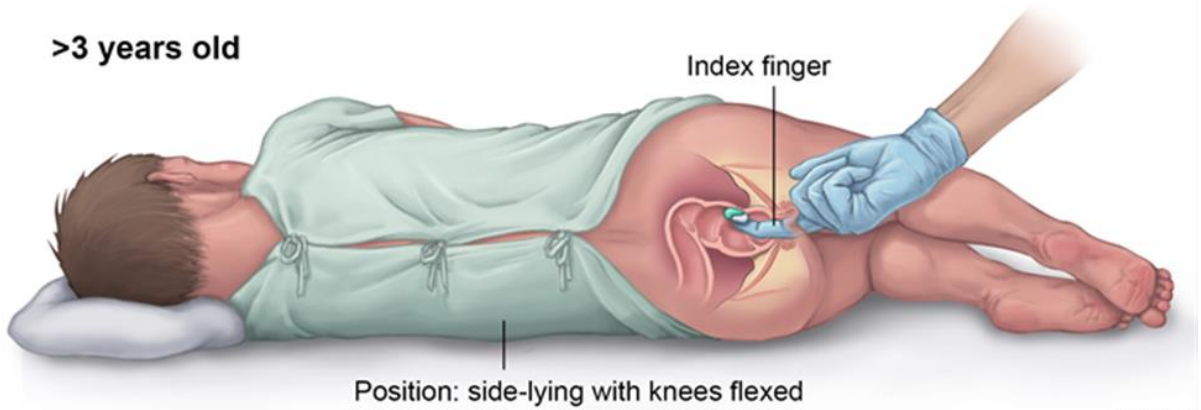
A reward system is one of the behavioral strategies used in the treatment of functional incontinence (due to constipation). The reward is given to encourage the child's involvement in the treatment to restore normal bowel function. Rewards are given for the child's effort and participation, not for having bowel movements while sitting on the toilet.

Administering rectal suppository in children

<3 years old



>3 years old



Vaccines

- It should be administered at specific ages and intervals as passive placental immunity decreases and the child's immune system is developed enough to produce antibodies in response to the vaccine.

The nurse should always assess for allergies to vaccine components (eg, neomycin, gelatin, yeast) and screen for an allergy to latex (eg, lips swell with bananas, kiwis, or latex balloons).

Common misperceptions of contraindications to immunization:

- Mild illness (with or without an elevated temperature)
- Currently taking antibiotics
- Mild site reactions (eg, swelling, erythema, soreness)
- Recent infection exposure
- Penicillin allergy

The Centers for Disease Control and Prevention (CDC) recommends that the first dose of **MMR vaccine** be given to children between age **12-15 months** to ensure optimal vaccine response. However, the vaccine is safe for children age <12 months; it could provide some protection or modify the clinical course of the disease if administered within 72 hours of the child's initial measles exposure. Immunoglobulin, if administered within 6 days of exposure, is also utilized as post-exposure prophylaxis.

A child who receives the MMR vaccine prior to the first birthday will need to be revaccinated at age 12-15 months and again between age 4-6 years.





The normal MMRV vaccine reactions that occur within 5-12 days after vaccination include mild fever and rash, irritability and restlessness, and swelling and erythema at the injection site. Febrile seizure is a rare but more serious reaction to the vaccine.

Immunization Schedule						
Birth	1 month	2 months	4 months	6 months	12 months	15 months
Hep B	Hep B			Hep B		
		DTaP	DtaP	DtaP		DtaP
		RV	RV	RV		
		Hib	Hib	Hib	Hib	
		IPV	IPV	IPV		
		PCV	PCV	PCV	PCV	
					MMR	
					VZV	
					Hep A	

Hep A/B = hepatitis A/B
DTaP = diphtheria, tetanus toxoids, acellular pertussis
RV = rotavirus
Hib = *Haemophilus influenzae* type b conjugate vaccine
IPV = inactivated poliovirus
PCV = pneumococcal conjugate vaccine
MMR = Measles, mumps & rubella
VZV = varicella zoster virus
 **the influenza vaccine is recommended yearly beginning at age 6 months

Nursing interventions for a newborn immediately after delivery include:

- **Standard precautions** - The unbathed newborn is covered in maternal **blood and bodily fluid**. Standard precautions (e.g., gloves) are implemented when contact with blood or bodily fluid is anticipated.
- Maintain a **clear airway** - Suction the pharynx first followed by the nasal passages to prevent aspiration if the newborn gasps with nasal suctioning.
- **Thermoregulation** (97.5-99 F [36.4-37.2 C]) reduces oxygen and stored calorie consumption. Hypothermia predisposes the newborn to metabolic acidosis, hypoxia, and shock. A radiant warmer is used while performing assessments and interventions. Use pre-warmed linens, an infant stocking cap, and a thermal skin sensor for monitoring. Skin-to-skin contact aids in thermoregulation.
- **Vitamin K** is administered **intramuscularly** in the vastus lateralis (mid anterior lateral thigh) within 6 hours of birth to prevent bleeding due to absence of vitamin K-producing intestinal bacteria.
- **Ophthalmic ointment** - Prophylactic antibiotic eye ointment for *Neisseria gonorrhoeae* is legally required; application may be delayed up to 1 hour after delivery.
- **Initial bathing of the newborn** is limited to removing blood, bodily fluids, or meconium. Vernix caseosa, a waxy, white coating, protects the skin and should not be vigorously removed.

	Stage	What happens at this stage?
	<p>SENSORIMOTOR (0-2 years)</p>	<ul style="list-style-type: none"> • Understands world through senses and actions • You can only teach only in the present <ul style="list-style-type: none"> ▪ Think present tense ▪ Just tell them ▪ Children at this age don't understand play
	<p>PRE-OPERATIONAL (2-7 years)</p>	<ul style="list-style-type: none"> • Understands world through language and mental images • They are fantasy-oriented, imaginative, and illogical, their thinking obeys no rules. • Able to understand the future and the past
	<p>CONCRETE OPERATIONAL (7-12 years)</p>	<ul style="list-style-type: none"> • Understands world through logical thinking and categories • Children in this age group are rule-oriented <ul style="list-style-type: none"> ▪ Live and Die by the Rules and Cannot Abstract • Teach them ahead of time • Teach them what you'll do and how to do skills • Use age-appropriate reading and demonstration (skill)
	<p>FORMAL OPERATIONAL (12 & Up)</p>	<ul style="list-style-type: none"> • Understands worlds through hypothetical thinking and scientific reasoning • They can abstract and think Cause and Effect • Teach them like an adult • When is the first age a child can manage his care? <ul style="list-style-type: none"> ▪ 2 years old ▪ Manage means making decisions which require the person to abstract

KIDS TOYS

When you select toys and play activities for children, there are three things to consider:



1. Is it safe?
2. Is it age appropriate?
3. Is it feasible?
 - ~Is it possible to do easily or conveniently? *i.e., swimming in hospital with body cast*

Safety

- Size (no small toys for kids under 4)
- NO **Metal** (or **dye-cast**) if oxygen is in use
 - Think of a flint-sparks!
- Beware of **fomites**
 - A fomite is a non-living object that harbors microorganisms, such as stuffed animals—the worst type of fomites
 - Hard plastic toys are fine ... They can easily be disinfected

Remember!

- ✓ If you have a child who is immunosuppressed, give them a hard plastic action figure. It can easily be disinfected

	Stage	Best Choice of Toys
	0-6 MONTHS (infants)	<ul style="list-style-type: none"> • Sensorimotor. Best toy is a musical mobile (Best choice) • Toy should be large but soft (2nd best choice)
	6-9 MONTHS	<ul style="list-style-type: none"> • Object permanence. Best toy teaches them to Cover/Uncover • This is to teach them that the object is still there even if they can't see it <i>Examples are: Jack-in-the-Box and Peek-a-Boo</i> • Toy should be large but firm • Worse toy after 6 months is the Musical Mobile because of the risk of strangulation



9-12 MONTHS

- **Vocalization.** Best toys are **speaking** or **verbal** toys
- Good list of toys are: **Tickle me Elmo, Woody Cowboy, See and Say-Barnyard Friends, Talking books**
- **For purposeful play,** the infant should be **at least 9 months** or older.
These words mean **purposeful** play: **build, sort, stack, make, and construct**
- Baby in womb for 9 months, another 9 months for purposeful play



1-3 YEARS (Toddlers)

- **Work on Gross Motor skills,** which is **running, jumping**
- Best toys for this age group are Push/Pull toys
Examples are: **Lawn mowers, Wagon, dog with floppy feet**
- They can paint (They use the hand to paint)
- They are characterized **Parallel Play**
Toddlers engage in **parallel play,** which involves playing alongside, not with, other children. Activities such as playing with dolls or toy cars, pushing and pulling large toys, smearing paint, and digging in a sandbox encourage parallel play.



3-6 YEARS (Preschoolers)

- **Work on fine motor skills**
- Therefore, preschoolers have **finger dexterity;** hence, can write, draw, use colored pencils, scissors
- Work on balance—Dance, ice skates, tricycles, tumbling
- They are characterized by **Cooperative Play**
 - Need to cooperate in Preschool (= Pretend)
 - You'd be the sheriff, I'll be robber ...
- **Highly imaginative**



**7-11 YEARS
(School age)**

- **Concrete**
- Characterized by the “3 Cs”
 1. **Creative**—Give them blank paper to draw, they like to get involved (Toys: Legos, Transformers)
 2. **Collective**—Baseball cards, Webkinz, Barbies, Beanie Babies
 3. **Competitive**—Winner/losers



**12-18 YEARS
(Adolescents)**

- **Peer group association**
- Allow adolescents to be in each other's rooms unless one of them has been/is
 1. Recently post-op for <12 hrs
 2. Immunosuppressed
 3. Contagious

Remember!

- ✓ When given a variety of ages to choose from, always go **younger** because children **regress**, when sick you want to give them **time to grow**.
- ✓ **Adolescence in psychosocial development is marked by risk-taking behaviors, a sense of invincibility, the need for independence, and a strong connection to peers.**

SBAR Communication Tool

S	Situation This is (name), a nurse on _____ unit. I am calling about (client name) I am calling to report _____ (e.g., abnormal vital signs).
B	Background (Client name) was admitted with (diagnosis) on (date). (Client name) has had _____ procedure/test. (Client name)'s condition changed (time period).
A	Assessment The current vital signs are _____. I think _____ problem is occurring and I have already intervened with _____. OR I don't know what is causing this change, but (client name)'s condition is declining.
R	Recommendation/Request I need you to _____. OR Come and see (client's name). OR How would you like me to proceed?

END