



# CHILD AND ADOLESCENT NURSING PRACTICUM

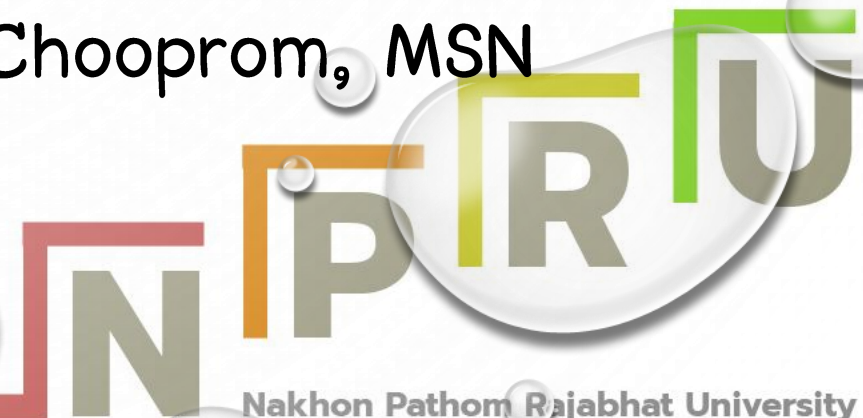
## TOPIC 3

# PHYSICAL ASSESSMENT THE OF CHILD



By

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## OBJECTIVES

The topic aims to develop in students an understanding of, and an ability to do the physical assessment the of child



## PHYSICAL ASSESSMENT THE OF CHILD

### IMPORTANT POINTS TO REMEMBER:

- The examination of infants and children is an art, demanding qualities of understanding, sympathy and patience.
- Heart rate, Respiratory rate, BP, liver size, heart size varies with age.
- Keep disturbing or painful procedures to the end.
- It is not necessary to be systemic in your examination, but should be complete.





## PHYSICAL ASSESSMENT THE OF CHILD

### PREPARATION OF THE CHILD

- Child's perception of painful procedures- tell child what will happen within their scope of understanding
- Cooperation usually enhanced with parent's presence unless an adolescent, then give choice
- Age-appropriate techniques- i.e., being with games and non-invasive procedures
- Use non-threatening approach
- Do as much as possible first without touching



## PHYSICAL ASSESSMENT THE OF CHILD

### REVIEW OF SYSTEMS

- The review of systems is a specific review of each body system following an order similar to that of the physical examination.
- Begin the review of a specific system with a broad statement such as “How has your child’s general health been?” or “Has your child had any problems with his eyes?”
- If the parent states that the child has had problems with some body function. “Tell me more about that.”



## PHYSICAL ASSESSMENT THE OF CHILD

### GENERAL

- Overall state of health, fatigue, recent or unexplained weight gain or loss (period of time for either), contributing factors (change of diet, illness, altered appetite)
- Exercise tolerance, fevers (time of day), chills, night sweats (unrelated to climatic conditions), frequent infections, general ability to carry out activities of daily living.





## PHYSICAL ASSESSMENT THE OF CHILD

### INTEGUMENT

- Pruritus, pigment or other color changes, acne, eruptions, rashes(location), tendency for bruising, petechiae, excessive dryness, general texture.
- Disorders or deformities of nails, hair growth or loss, hair color change (for adolescents, use of hair dyes or other potentially toxic substances, such as hair straighteners)



## PHYSICAL ASSESSMENT THE OF CHILD

### HEAD & EYES:

- **Head**—Headaches, dizziness, injury and size.
- **Eyes**—Visual problems (behaviors indicative of blurred vision, such as bumping into objects, sitting close to television, holding a book close to face, writing with head near desk, squinting, rubbing the eyes, bending head in an awkward position), cross eyes (strabismus), eye infections, edema of the eyelids, excessive tearing, use of glasses or contact lenses, date of last optic examination.





## PHYSICAL ASSESSMENT THE OF CHILD

### EARS, NOSE AND MOUTH :

- **Ears**—Earaches, discharge, evidence of hearing loss (ask about behaviors, such as the need to repeat requests, loud speech, inattentive behavior), results of any previous auditory testing. •
- **Nose**—Nosebleeds (epistaxis), constant or frequent runny or stuffy nose, nasal obstruction (difficulty breathing), alteration or loss of sense of smell
- **Mouth**—Mouth breathing, gum bleeding, toothaches, tooth brushing, use of fluoride, difficulty with teething (symptoms), last visit to dentist (especially if temporary dentition is complete), response to dentist.



## PHYSICAL ASSESSMENT THE OF CHILD

### THROAT, NECK AND CHEST:

- **Throat**—Sore throats, difficulty swallowing, choking (especially when chewing food; may be from poor chewing habits), hoarseness or other voice irregularities.
- **Neck**—Pain, limitation of movement, stiffness, difficulty holding head straight (torticollis), thyroid enlargement, enlarged nodes or other masses.
- **Chest**—Breast enlargement, discharge, masses, enlarged axillary nodes (for adolescent girls, ask about breast self-examination).



## PHYSICAL ASSESSMENT THE OF CHILD

### RESPIRATORY:

- **Chronic cough** frequent colds (number per year), wheezing, shortness of breath at rest or on exertion, difficulty breathing, sputum production, infections (pneumonia, tuberculosis),
- **Date of last chest x-ray examination, skin reaction from tuberculin testing.**





## PHYSICAL ASSESSMENT THE OF CHILD

### CARDIOVASCULAR AND GASTROINTESTINAL :

- Cardiovascular—Cyanosis or fatigue on exertion, history of heart murmur or rheumatic fever, anemia, date of last blood count, blood type, recent transfusion.
- Gastrointestinal (questions in regard to appetite, food tolerance, and elimination habits are asked elsewhere)— Nausea, vomiting (not associated with eating; may be indicative of brain tumor or increased intracranial pressure), jaundice or yellowing skin or sclera, belching, flatulence, recent change in bowel habits (blood in stools, change of color, diarrhea or constipation)



## PHYSICAL ASSESSMENT THE OF CHILD

### GENITOURINARY :

- **Genitourinary**—Pain on urination, frequency, hesitancy, urgency, hematuria, nocturia, polyuria, unpleasant odor to urine, force of stream, discharge , change in size of scrotum.
- **Date of last urinalysis** (for adolescents, sexually transmitted infection, type of treatment; for male adolescents, ask about testicular self-examination).



## PHYSICAL ASSESSMENT THE OF CHILD

### GYNECOLOGIC :

- Menarche, date of last menstrual period, regularity or problems with menstruation, vaginal discharge, pruritus(ITCHING).
- Date and result of last Papanicolaou(Pap)test
- If sexually active, type of contraception.
- Sexually transmitted infection and type of treatment.





## PHYSICAL ASSESSMENT THE OF CHILD

### **MUSCULOSKELETAL :**

- Weakness, clumsiness, lack of coordination, unusual movements, back or joint stiffness, muscle pains or cramps, abnormal gait, deformity, fractures, serious sprains, activity level.



## PHYSICAL ASSESSMENT THE OF CHILD

### NEUROLOGIC :

- Seizures, tremors, dizziness, loss of memory, general affect, fears, nightmares, speech problems, any unusual habits.

### ENDOCRINE:

Intolerance to weather changes, excessive thirst or urination, excessive sweating, salty taste to skin, signs of early puberty.



## PHYSIOLOGIC MEASUREMENTS

- Physiologic measurements, key elements in evaluating physical status of vital functions, include temperature, pulse, respiration, and BP.
- Compare each physiologic recording with normal values for that age group



## Acceptable ranges for physiological variables

Credit: The Royal Children's Hospital Melbourne, July (2020)

Age	Approximate Weight (kg)	Systolic BP (mmHg)	Heart Rate (Beats/minute)	Respiratory Rate (Breaths/minute)
Term	3.5	60-95	120-185	25-60
3 months	6	60-105	115-180	25-60
6 months	8	75-105	110-180	20-55
1 year	10	70-105	105-180	20-45
2 years	12	70-105	95-175	20-40
4 years	15	75-110	80-150	17-30
6 years	20	80-115	75-140	16-30
8 years	25	80-115	70-130	16-30
10 years	30	85-120	60-130	15-25
12 years	40	90-120	65-120	15-25
14 years	50	90-125	60-115	14-25
16 years	60	90-130	60-115	14-25
17+ years	65	90-135	60-115	14-25

For emergency advice and paediatric or neonatal ICU transfers, see [Retrieval services](#)



## PHYSIOLOGIC MEASUREMENTS

### Temperature

- Temperature is the measure of heat content within an individual's body.
- The core temperature most closely reflects the temperature of the blood flow through the carotid arteries to the hypothalamus.
- Sites: oral, axillary, ear based (Aural), rectal, Temporal Artery (An infrared sensor probe scans across forehead, capturing heat from arterial blood flow).



# PHYSIOLOGIC MEASUREMENTS

## Temperature

**1S**  
Fast measurement

**°C/°F Unit conversion**

**Auto shut-off function**

**Surface temperature**

**Memory for 32 groups of data**

**Fever alarm function**

<b>Body</b> 36.3 😊	<b>Body</b> 37.5 😐	<b>Body</b> 38.8 😞
normal	low fever	high fever







## PHYSIOLOGIC MEASUREMENTS

### Pulse

- Pulse A satisfactory pulse can be taken radially in children older than 2 years of age.
- However, in infants and young children, the apical impulse(heard through a stethoscope held to the chest at the apex of the heart)is more reliable.
- Count the pulse for 1 full minute in infants and young children because of possible irregularities in rhythm. However, when frequent apical rates are necessary, use shorter counting times (e.g., 15- or 30-second intervals).



## PHYSIOLOGIC MEASUREMENTS

### Respiration

- Count the respiratory rate in children in the same manner as for adult patients.
- However, in infants, observe abdominal movements because respirations are primarily diaphragmatic.
- Because the movements are irregular, count them for 1 full minute for accuracy.



## PHYSIOLOGIC MEASUREMENTS

### Blood Pressure Blood Pressure

- Blood pressure measurement by noninvasive methods is part of a routine vital sign determination.
- Measure BP annually in children 3 years of age through adolescence and in children with symptoms of hypertension, children in emergency departments and intensive care units, and high-risk infants





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## NEXT TOPIC

# FEEDING & FOOD SUPPLEMENTATION



See you soon....

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