Illinois ESF-8 Plan: Pediatric and Neonatal Surge Annex

Pediatric and Neonatal Care Guidelines

February 2015
# Table of Contents

1. Burn Care Guideline  
2. Inpatient Treatment and Monitoring Intervention Care Guideline  
3. Newborn Care Guideline  
4. Obstetrical Care Guideline  
5. Initial Assessment of the Pregnant Patient  
6. Pandemic Care Guideline  
7. Premature Newborn Care Guideline  
8. Radiation Exposure Care Guideline  
9. Respiratory Care Guideline  
10. Shock Care Guideline  
11. Trauma and Blast Injury Care Guideline  
12. Sample admission orders  
13. Acronyms  
14. References
Purpose: To provide guidance to practitioners caring for pediatric burn patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

72 Hour Care Guidelines for Pediatric Burn Patients if Transfer to a Hospital with Burn Capabilities is Not Feasible

**Initial Patient Treatment**

- Stop the burning process
- Use universal precautions
- Remove all clothing and jewelry
- Prior to initiating care of the patient with wounds, it is critical that health care providers take measures to reduce their own risk of exposure to potentially infectious substances and/or chemical decontamination. Rinse liberally with water, according to protocol, if suspected chemical exposure. Apply clean, dry dressing(s) initially to avoid hypothermia.
- Apply clean DRY sheet or bedding to prevent hypothermia.
- Consult Pediatric Care Medical Specialist (PCMS) and/or the State Burn Coordinating Center (SBCC) for assistance with care of the acutely and critically ill patient, to individualize patient care; if patient does not improve and needs to be transferred; and as needed for further support and consult.
- Comfort care patients: During a burn MCI, resources may not be available to treat those with extensive burn injuries. There are sections within the following guidelines that provide guidance to providers in order to address their needs. Consult the SBCC or the PCMS for additional assistance from palliative care experts.

### Primary Assessment, Monitoring, Interventions and Key Points

<table>
<thead>
<tr>
<th>Assessment and Monitoring</th>
<th>Interventions</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Airway Maintenance with Cervical Spine Protection</strong></td>
<td><strong>Airway Maintenance with Cervical Spine Protection</strong></td>
<td><strong>Airway Maintenance with Cervical Spine Protection</strong></td>
</tr>
<tr>
<td>- Assess throat and nares.</td>
<td>- Chin lift/jaw thrust with C-spine precautions as needed.</td>
<td>- Airway edema increases significantly after IV/IO fluids are started.</td>
</tr>
<tr>
<td>- Signs of airway injury:</td>
<td>- IMMOBILIZE SPINE as indicated. Position for optimal airway and suction as needed. Position infants and children &lt; 2 yrs supine on a backboard with a recess for the head or use a pad under the back from the shoulders to the buttocks.</td>
<td>- Stridor or noisy breath sounds indicate impending upper airway obstruction.</td>
</tr>
<tr>
<td>o Hypoxia</td>
<td>o Place an oral pharyngeal airway or cuffed endotracheal tube (ETT) in the unconscious</td>
<td>- Younger children and those with larger burns are more likely to require intubation due to the smaller diameter of the child’s airway and the need for significant fluid volumes during resuscitation.</td>
</tr>
<tr>
<td>o Facial burns</td>
<td></td>
<td>o Prophylactic intubation is preferred because the ensuing edema obliterates landmarks needed for successful intubation.</td>
</tr>
<tr>
<td>o Carbonaceous sputum</td>
<td></td>
<td>o It is critical that the ETT is secured well. An ETT that</td>
</tr>
<tr>
<td>o Stridor</td>
<td></td>
<td>is not well secured can lead to intubation failure and</td>
</tr>
<tr>
<td>o Hoarseness</td>
<td></td>
<td>significant complications.</td>
</tr>
<tr>
<td>o Nasal singe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o History of a closed space fire</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Last updated: 2014
### Assessment and Monitoring

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>becomes dislodged may be impossible to replace due to the edema of the upper airway.</td>
</tr>
</tbody>
</table>
| - Intubate early with cuffed ETT.  
- Secure ETT with ties passed around the head; do not use tape on facial burns since it will not adhere to burned tissue.  
- Insert gastric tube on all intubated patients.  
- **Comfort Care Patients**: Patients triaged as comfort care patients should not be intubated. Administer oxygen to aid comfort and prevent air hunger. Also consider pain management. |

### Breathing and Ventilation

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Breathing and Ventilation | CO levels decrease by half (½) every 40 minutes while on 100% \( \text{FiO}_2 \). CO level goal is <10%.  
An escharotomy is an incision performed longitudinally through burned tissue down to subcutaneous tissue over the entire involved area of full thickness circumferential (or nearly circumferential burn) that is causing constriction and loss of peripheral perfusion or airway constriction. A chest escharotomy may be indicated in circumferential or full thickness chest burns due to location or depth of burn in the trunk area, which may interfere with ventilation. |
| - Assess for appropriate rate and depth of respirations with adequate air exchange.  
- Monitor pulse oximetry while checking carbon monoxide (CO) level (as needed).  
- If circumferential torso burns, monitor chest expansion closely.  
- Obtain Arterial Blood Gas (ABG).  
- Obtain carboxyhemoglobin (COHb) level if suspected inhalation injury. |

### Circulation with Hemorrhage Control

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Circulation with Hemorrhage Control | Cardiac monitoring may be needed if there is an electrical injury, concurrent trauma or cardiac issues  
Dysrhythmias may be the result of an electrical injury  
**Comfort care patients**: IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema. |
| - Continuous cardiac monitoring as needed.  
- Control any signs of hemorrhage. |

### Circulation with Hemorrhage Control

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Circulation with Hemorrhage Control | Cardiac monitoring may be needed if there is an electrical injury, concurrent trauma or cardiac issues  
Dysrhythmias may be the result of an electrical injury  
**Comfort care patients**: IVs should be started for the administration of medications for pain and anxiety. Do not administer large volumes of fluid. Excessive fluid will result in decreased circulation and increased pain due to edema. |
| - Two large bore peripheral IVs in non-burned extremities (secure well).  
- If unable to secure peripheral IV in non-burned extremity, burned extremity can be used if necessary; suture IV in place.  
- If unable to establish a peripheral IV, place an intraosseus (IO).  
- Pediatrics: 20 mL/kg bolus with Lactated Ringers (LR) initially. |
### Assessment and Monitoring

<table>
<thead>
<tr>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic checks every 4 hours and PRN.</td>
</tr>
<tr>
<td>- Determine level of consciousness.</td>
</tr>
<tr>
<td>- Obtain Glasgow Coma Scale</td>
</tr>
<tr>
<td>- Consider using “AVPU.”</td>
</tr>
<tr>
<td>- A: Alert</td>
</tr>
<tr>
<td>- V: Responds to verbal stimuli</td>
</tr>
<tr>
<td>- P: Responds to painful stimuli</td>
</tr>
<tr>
<td>- U: Unresponsive</td>
</tr>
<tr>
<td>Obtain glucose level</td>
</tr>
</tbody>
</table>

### Interventions

<table>
<thead>
<tr>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat cause of altered mental status as indicated:</td>
</tr>
<tr>
<td>- Hypoglycemia:</td>
</tr>
<tr>
<td>- Dose: Dextrose 0.5-1 g/kg IV/IO</td>
</tr>
<tr>
<td>- Birth-28 days: D10W: 2 mL/kg IV</td>
</tr>
<tr>
<td>- Infants &gt; 28 days-1 y/o: D12.5%W: 5-10 mL/kg IV/IO</td>
</tr>
<tr>
<td>- 1 y/o-8 y/o: D25W: 2-4 mL/kg IV/IO</td>
</tr>
<tr>
<td>- &gt; 8 y/o: D50W: 1-2 mL/kg IV/IO</td>
</tr>
</tbody>
</table>

### Key Points

<table>
<thead>
<tr>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>If altered neurological status, consider the following:</td>
</tr>
<tr>
<td>- Associated injuries</td>
</tr>
<tr>
<td>- CO poisoning</td>
</tr>
<tr>
<td>- Substance abuse</td>
</tr>
<tr>
<td>- Hypoxia</td>
</tr>
<tr>
<td>- Hypoglycemia (&lt;60 mg/dL in infants/children; &lt;50 mg/dL in neonates)</td>
</tr>
<tr>
<td>- Pre-existing medical condition</td>
</tr>
</tbody>
</table>

### Exposure

<table>
<thead>
<tr>
<th>Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor temperature</td>
</tr>
</tbody>
</table>

### Assessment and Monitoring (Cont.)

#### Complete Physical Exam

- Head to toe exam

### Interventions and Key Points (Cont.)

#### Complete Physical Exam

- Due to increased catecholamines and hypermetabolism associated with burn
## Assessment and Monitoring

- **Vital signs:** Perform as indicated in hospital policy. May need to perform more frequently if patient is unstable.
  - Heart rate (HR)
  - Blood pressure (BP)
  - Capillary refill
  - Temperature
  - Skin color of unburned skin

- **Determine extent/size of burn by calculating the TBSA using:**
  - Rule of Nines or Rule of the Palm (See pg. 14 for printable version)
  - Lund-Browder chart (See pg. 13 for printable version)

- **Determine the depth of the burn** (See pg. 12 for more information)
  - *Superficial (1st degree)*
    - Involves the epidermis
    - Appearance: Red (e.g., sunburn)
    - Do not include when calculating TBSA
  - *Partial thickness (2nd degree)*
    - Involves the entire epidermis and a variable portion of the dermis
    - Appearance: red, blistered and edematous
  - *Full thickness (3rd degree)*
    - Involves the destruction of the entire epidermis and dermis
    - Appearance: white, brown, dry, leathery with possible coagulated vessels

- If camera is available, take pictures of initial burn injuries to document progression of burn injury.

- Labs on admission and every day as indicated by medical condition:
  - Electrolyte panel
  - Complete blood count (CBC)
  - ECG for electrical injury or cardiac history
  - ABG with COHb
  - Cardiac panel for electrical injury
  - CXR if intubated, inhalation injury suspected or underlying

## Interventions and Key Points

- **Injures,** the HR will be increased. Sustained tachycardia may indicate hypovolemia, inadequate oxygenation, unrelieved pain or anxiety.

- **Oral rehydration can be used in the following pediatric patients:**
  - Patients not intubated.
  - Injury not an electrical injury.
  - Awake and alert with < 10% TBSA.
  - Contact the SBCC for assistance with oral rehydration.
  - Monitor quality and quantity of urine output on patient’s receiving oral rehydration.

- **IV/IO fluid burn resuscitation-Use Lactated Ringers:**
  - When supplies of LR are depleted, 0.9 NS and 0.45 NS or colloids can be used for fluid resuscitation. Do not use fluid containing glucose for fluid resuscitation.
  - 3 mL x wt (kg) x % TBSA = total for first 24 hours post burn.
  - Administer half of the above amount in first 8 hours post burn.
  - Administer remaining amount over next 16 hours post burn.

- **Pediatrics < 10 kg:** Due to limited glycogen stores, in addition to resuscitation IV/IO fluids, administer D5% LR at maintenance rate:
  - To calculate maintenance IVF rate for children:
    - 4 mL/kg/hr for 1st 10 kg
    - + 2 mL/kg/hr for 2nd 10kg
    - + 1 mL/kg/hr for each additional kg over 20kg = IV/IO fluid maintenance rate

- **Tetanus prophylaxis,** unless received within last 5 years.

- Place a soft feeding tube for all intubated patients.

- **Place a soft feeding tube** for intubated patients.

- **If signs of circulation deficit are present,** contact the SBCC.

- **Eyes:**
  - Remove contact lens prior to eyelid swelling if facial involvement.
  - Fluorescein should be used to identify corneal injury.
### Assessment and Monitoring

- pulmonary condition.
- Monitor glucose at least every 2 hours x 24 hours.
- Monitor for the following signs and symptoms in full thickness, circumferential burn injuries which may indicate a circulation deficit and possible need for escharotomy:
  - Pallor or cyanosis of distal unburned skin on a limb
  - Capillary refill > 5 seconds
  - Unrelenting deep tissue pain
  - Progressive loss of sensation or motor function
  - Progressive decrease or absence of pulses
  - Inability to ventilate in patients with deep circumferential burns of the chest

### Interventions and Key Points

- If eye involvement or facial burns consider, consulting an ophthalmologist.
- Consult with SBCC to determine if escharotomy is indicated and to receive guidance on performing an escharotomy.
- Finger escharotomies are rarely indicated.

### Comfort

- Frequent pain/sedation assessment
  - A minimum of every 4 hours
  - Before and after pain/sedation medication given
- Use age appropriate pain scales for pediatric patients (e.g., Wong Baker FACES, FLACC)

### Interventions and Key Points

- Emotional support and education is essential.
- IV/IO analgesia is preferred route during initial post injury period.
- Large amounts of IV/IO analgesic may be required to attain initial pain control.
  - Administer opioids in frequent (every 5 minutes) small to moderate doses until pain is controlled.
    - Morphine 0.1-0.2 mg/kg IV/IO (max 10mg/dose)
    - Fentanyl 1-2 mcg/kg/dose IV/IO/IN (not to exceed maximum adult dose)
  - Oxycodone PO
- Consider use of non-pharmacological techniques.
  - Examples:
    - < 2 y/o: distraction
    - 2-6 y/o: distraction, deep breathing
    - > 6 y/o: deep breathing, distraction, imagery
- Consider anti-anxiety medication in addition to pain medication.
  - Ativan PO/IV/IO
  - Versed IV/IO/IN
- Consider sedation for procedures and, if intubated:
  - Propofol
  - Ketamine
<table>
<thead>
<tr>
<th>Assessment and Monitoring</th>
<th>Interventions and Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wound Care</strong></td>
<td><strong>Wound Care</strong></td>
</tr>
<tr>
<td>• Assess the wound and monitor for:</td>
<td>• Pre-medicate patients for pain before wound care.</td>
</tr>
<tr>
<td>o Change in wound appearance</td>
<td>• In a mass casualty disaster situation wound care for patient with a &gt;20% TBSA burn can be performed once per day.</td>
</tr>
<tr>
<td>o Change in size of wound</td>
<td>• Contraindications for silver sulfadiazine (Silvadene):</td>
</tr>
<tr>
<td>o Signs or symptoms of infection</td>
<td>o Patient’s with a sulfa allergy</td>
</tr>
<tr>
<td></td>
<td>o On face due to pigment bleaching</td>
</tr>
<tr>
<td></td>
<td>o Children &lt; 2 years old</td>
</tr>
<tr>
<td></td>
<td>o During pregnancy</td>
</tr>
<tr>
<td></td>
<td>Instead use another topical or wound coverage product.</td>
</tr>
<tr>
<td></td>
<td>• Wash wounds with soap and warm tap water using a wash cloth.</td>
</tr>
<tr>
<td></td>
<td>o Remove water by patting dry</td>
</tr>
<tr>
<td></td>
<td>• Shave daily for burned scalps and faces.</td>
</tr>
<tr>
<td></td>
<td>• Perform wound care every day if using:</td>
</tr>
<tr>
<td></td>
<td>o Silver sulfadiazine (Silvadene) cream</td>
</tr>
<tr>
<td></td>
<td>o Bacitracin</td>
</tr>
<tr>
<td></td>
<td>• Debride ALL blisters except for:</td>
</tr>
<tr>
<td></td>
<td>o Intact blisters on hands and feet unless it is impeding range of motion to the joints,</td>
</tr>
<tr>
<td></td>
<td>o Weeping blister(s).</td>
</tr>
<tr>
<td></td>
<td>• Ear wound care:</td>
</tr>
<tr>
<td></td>
<td>o Ears are poorly vascularized and at risk for chondritis.</td>
</tr>
<tr>
<td></td>
<td>• How to apply silver sulfadiazine (Silvadene) cream:</td>
</tr>
<tr>
<td></td>
<td>o Apply thin layer enough so that the wound cannot be seen through the cream.</td>
</tr>
<tr>
<td></td>
<td>o The layer of silver sulfadiazine (Silvadene) should be thick enough to prevent the wound from drying out prior to the next dressing change.</td>
</tr>
<tr>
<td></td>
<td>o Cover with a dressing; the purpose of a dressing is to keep the cream from rubbing off before the next dressing change.</td>
</tr>
<tr>
<td></td>
<td>• How to apply Acticoat® dressing:</td>
</tr>
<tr>
<td></td>
<td>o Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered.</td>
</tr>
<tr>
<td></td>
<td>o Water should be used to keep the Acticoat® and overlying gauze moist to maintain the dressing’s antimicrobial activity. <strong>DO NOT use</strong></td>
</tr>
<tr>
<td>Assessment and Monitoring</td>
<td>Interventions and Key Points</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td><em>saline because it deactivates the silver’s antimicrobial ability</em>).</td>
</tr>
<tr>
<td></td>
<td>- Should be held in place with water-moistened gauze dressing.</td>
</tr>
<tr>
<td></td>
<td>- Dressing does not need to be changed for 7 days.</td>
</tr>
<tr>
<td></td>
<td>- The overlying gauze can be changed as necessary.</td>
</tr>
<tr>
<td></td>
<td>- If signs of infection appear, remove dressing to assess wound.</td>
</tr>
<tr>
<td></td>
<td>- Record the date of the application.</td>
</tr>
<tr>
<td>- Wrap fingers separately if burned.</td>
<td></td>
</tr>
<tr>
<td>- Place silver sulfadiazine (Silvadene) coated gauze between the toes.</td>
<td></td>
</tr>
<tr>
<td>- For extensive and severe burns to the face:</td>
<td></td>
</tr>
<tr>
<td>- Apply a double antibiotic ointment around the eyes and mouth to avoid cream from draining into them.</td>
<td></td>
</tr>
<tr>
<td>- Can use ophthalmic ointment around eyes.</td>
<td></td>
</tr>
<tr>
<td>- For moderate facial burns, Bacitracin or other antibiotic ointment can be used without a dressing.</td>
<td></td>
</tr>
<tr>
<td>- Genital/Perineal Burns</td>
<td></td>
</tr>
<tr>
<td>- Urinary catheter may be indicated for genitalia or perineal burns. Evaluate each patient individually to determine if needed.</td>
<td></td>
</tr>
<tr>
<td>- Apply lubricated gauze to labia and in the foreskin to prevent adhesions and decrease risk of infection in this area of high contamination.</td>
<td></td>
</tr>
<tr>
<td>- Elevate burned extremities above the level of the heart.</td>
<td></td>
</tr>
</tbody>
</table>

### Ongoing Assessment, Monitoring, Interventions and Key Points

<table>
<thead>
<tr>
<th>Assessment and Monitoring</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Airway and Breathing</strong></td>
<td><strong>Airway and Breathing</strong></td>
</tr>
<tr>
<td>- Obtain chest X-ray if intubated, inhalation injury suspected or underlying pulmonary condition.</td>
<td>- Supportive therapy and $O_2$; wean as appropriate.</td>
</tr>
<tr>
<td>- Chest X-ray will usually be clear on admit. If inhalation injury is present, the X-ray will show infiltrates around the second day correlating with a deteriorating oxygen status.</td>
<td>- HOB should be elevated 30 degrees to minimize facial and airway edema, unless contraindicated.</td>
</tr>
<tr>
<td>- Frequent suctioning is necessary to prevent occlusion of the airway and endotracheal tube. Anyone with an inhalation injury is subject to increased respiratory secretions and may</td>
<td>- Use reverse Trendelenburg for patients with C-spine precautions.</td>
</tr>
<tr>
<td>- Suction airway frequently.</td>
<td>- Suction airway frequently.</td>
</tr>
<tr>
<td>- <strong>Inhalation Injuries:</strong></td>
<td>- <strong>Inhalation Injuries:</strong></td>
</tr>
<tr>
<td>- Treatment for inhalation injury is supportive care and includes:</td>
<td>- Intubation as indicated</td>
</tr>
</tbody>
</table>
### Assessment and Monitoring

- Have a large amount of carbonaceous debris in the respiratory tract.

### Interventions

- Provide adequate sedation to prevent dislodgement of ETT
- Frequent suctioning
- Positive End Expiratory Pressure (PEEP) may improve ventilation
  - Secure ETT with ties instead of tape since tape will not adhere to burned tissue
  - Mark ETT at fixed position (teeth or gums not lips which may have swelling)

### Circulation

- Perform pulse checks (CMS) every 1 hour if there are circumferential burns on extremities.
  - Monitor pulses by palpation or doppler exam.
    - Decreased sensation
    - Severe unrelenting deep tissue pain
    - Diminished distal pulses
    - Capillary refill > 5 sec
- After 24-48 hrs decrease frequency of pulse checks to every 2 hours if stable.

#### Outputs of Resuscitation

- Insert arterial line.
- Insert urinary catheter.
- If urine output is < goal, ↑ fluids by 1/3.
  - Example: u/o for 20 kg pediatric patient = 10 mL/hr, fluid rate at 50 mL/hr, ↑ to 66 mL/hr
- If urine output is > goal, ↓ rate of infusion by 1/3.
  - Example: u/o for 20 kg pediatric patient = 30 mL/hr fluid rate at 50 mL/hr, ↓ to 33 mL/hr
- Upon completion of the resuscitation phase (24 hrs post burn), ↓ hourly fluid volume by 10% per hour to a maintenance fluid with D5 ½ NS with 20 mEq KCL/L.
- Myoglobin in urine:
  - Maintain urine output:
    - 2 mL/kg/hr
  - Increase fluid rate (LR).
- Sodium bicarbonate IV/IO may be administered to maintain alkaline urine, with a pH > 6.

### Circulation/Outputs of Resuscitation

- Monitor mean arterial blood pressure (MAP):
  - Goal for MAP is >60 mmHg
- Monitor hourly urine output:
  - Goal: 1 mL/kg/hr for children < 30 kg
- Monitor for myoglobin/pigment in urine (burgundy color).
- Additional resuscitation fluid needs can occur with:
  - Very deep burns
  - Inhalation injury
  - Associated injuries
  - Electrical injury
  - Delayed resuscitation
  - Prior dehydration
  - Alcohol or drug dependence
  - Small children
- Children and patients with preexisting cardiac disease are particularly sensitive to fluid management.
- Diuretics are not indicated in myoglobin in the urine.
- Monitor glucose at least every 2 hrs x 24 hours.

#### Circulation

- Elevate burned extremities on pillows or blankets to improve circulation and minimize edema.
- Circumferential chest injuries may become life threatening; an escharotomy may be necessary.
- Verify that pulselessness is not due to profound hypotension.
- Scrotal swelling, though often significant, does not require specific treatment.
### Assessment and Monitoring

- Assess bowel sounds to monitor for ileus.

### Interventions

#### Body Temperature
- Perform temperature checks based on hospital protocol.
- If unstable or significant burn, hourly vital signs may be indicated.

#### Body Temperature
- With 2nd and 3rd degree burns, patients may have difficulty regulating their temperature; monitor for hypo and hyperthermia.
- Keep patient normo-thermic, especially during wound care.
- Keep patient covered. When supplies of blankets are depleted, patients can be wrapped in plastic wrap or aluminum foil for insulation and warmth.
- Warm the room.
- Warm IV/IO fluid if possible, especially if patient is very hypothermic.

### Nutrition

- Obtain dry weight on admission.
- See Nutritional Algorithm for Burn Patients on page 15.

#### Increased protein needs.
- 20 - 23% of calories should be from protein in TBSA >10% (approximately 2.5 - 4.0 grams protein/kg)

#### Dietary consult with daily calorie counts.
- Usual Kcal needs = Resting Energy Expenditure (REE) x 30%

#### Regular high calorie, high protein diet if able to take PO.
- If unable to maintain adequate caloric requirements, initiate tube feedings.

#### No free water drinks (plain water) if taking PO, only high calorie liquids.

#### If intubated, begin tube feedings at full strength increasing to goal rate.

#### Ensure stool softeners are ordered to prevent constipation due to pain medications.

#### Begin enteral nutrition as soon as possible.

#### Soft feeding tubes are preferred over hard salem sump nasogastric tube.

#### Consider GI stress ulcer prophylaxis (AHRQ, 2008).
- H2 antagonists, cytoprotective agents or proton pump inhibitors.
- Do not use antacids as stress ulcer prophylaxis.

### Psychosocial

- Explain any procedures.
- Involve patient and family.
- Consider social worker consultation.
- Offer spiritual care.
- Consult child life specialists, if available.
- Child’s needs and understanding of the injury and care will vary based on their developmental level.
  - Infants
<table>
<thead>
<tr>
<th>Assessment and Monitoring</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Learn through sensory stimulation (especially touch) and movement.</td>
<td></td>
</tr>
<tr>
<td>▪ Can experience separation anxiety from family/care taker.</td>
<td></td>
</tr>
<tr>
<td>o Toddler/Preschool</td>
<td></td>
</tr>
<tr>
<td>▪ May see the burn injury as punishment for being “bad” so at risk for ineffective coping.</td>
<td></td>
</tr>
<tr>
<td>▪ Routine is important so coordinate procedures around daily routines.</td>
<td></td>
</tr>
<tr>
<td>o School age</td>
<td></td>
</tr>
<tr>
<td>▪ Anxiety can be decreased by providing child education about processes and involving child in care.</td>
<td></td>
</tr>
<tr>
<td>o Adolescent</td>
<td></td>
</tr>
<tr>
<td>▪ Body image is significant concern.</td>
<td></td>
</tr>
</tbody>
</table>

**Infection Control**

- Utilize universal precautions.
- If wounds are exposed:
  - o Apply gown, mask and gloves to protect patient.
- No systemic antibiotics are required for the burn injuries.

**Mobility**

- In a disaster, therapists may just splint patients in functional positions and help with dressings.
- Obtain physical therapy /occupational therapy consult.
- HOB elevated at all times.
- Elevate burned extremities above the level of the heart.
- Neck burns
  - o Maintain the head in a neutral position.
  - o No pillows or blankets under the head flexing the neck forward.
- Axilla burns
  - o Keep arms extended to decrease contractures.
- Ear burns
  - o No external pressure should be applied.
  - o No pillows or blankets under the head.
- Out of bed (OOB) - If legs are burned, apply ace wraps when OOB.
- Encourage active range of motion hourly when awake.
- Encourage activities of daily living.

### Proper Positioning of a Burn Patient

<table>
<thead>
<tr>
<th>Area Involved</th>
<th>Contracture Predisposition</th>
<th>Contracture Preventing Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior neck</td>
<td>Flexion</td>
<td>Extension, no pillows</td>
</tr>
</tbody>
</table>
## Assessment and Monitoring

<table>
<thead>
<tr>
<th>Area</th>
<th>Movement</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior axilla</td>
<td>Shoulder adduction</td>
<td>90° abduction, neutral rotation</td>
</tr>
<tr>
<td>Posterior axilla</td>
<td>Shoulder extension</td>
<td>Shoulder flexion</td>
</tr>
<tr>
<td>Elbow/Forearm</td>
<td>Flexion/pronation</td>
<td>Elbows extended, forearm supinated</td>
</tr>
<tr>
<td>Wrist</td>
<td>Flexion</td>
<td>15°–20° extension</td>
</tr>
<tr>
<td>Hands:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCPs</td>
<td>Hyperextension</td>
<td>70°–90° flexion</td>
</tr>
<tr>
<td>IPs</td>
<td>Flexion</td>
<td>full-extension</td>
</tr>
<tr>
<td>Palmar Burn</td>
<td>Finger flexion, thumb opposition</td>
<td>All joints full extension, thumb radially abducted</td>
</tr>
<tr>
<td>Chest</td>
<td>Lateral/anterior flexion</td>
<td>Straight, no lateral or anterior flexion</td>
</tr>
<tr>
<td>Hips</td>
<td>Flexion, adduction, external rotation</td>
<td>Extension, 10° abduction, neutral rotation</td>
</tr>
<tr>
<td>Knees</td>
<td>Flexion</td>
<td>Extension</td>
</tr>
<tr>
<td>Ankles</td>
<td>Plantar flexion</td>
<td>90° dorsiflexion</td>
</tr>
</tbody>
</table>

### Splinting materials:
- Use either ace/elastic wraps, gauze roll/wraps or strappings with post-mold material (e.g., thermoplastic-perforated).

## Reunification

During a large scale disaster, family members may become separated. It is crucial that staff attempt to reunify patients with their family. Children are more vulnerable to maltreatment, abuse and abduction, if separated from their care giver. Community partners, such as the American Red Cross and National Center for Missing and Exploited Children, can assist with this process. The reunification process begins with EMS at the scene and, if possible, trying to keep known family members together when making transport decision. The Patient Identification Tracking Form (Attachment 9 in Burn Surge Annex) should be utilized for all patients to assist with the reunification process.
## Attachement 14: Pediatric Burn Protocols

### Assess Degree of Injury

<table>
<thead>
<tr>
<th>Degree of Injury</th>
<th>Appearance</th>
<th>Surface</th>
<th>Sensation</th>
<th>Time to Healing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st degree/superficial</td>
<td>Pink or red</td>
<td>Dry</td>
<td>Painful</td>
<td>4-5 days</td>
</tr>
<tr>
<td>2nd degree/superficial partial</td>
<td>Pink, clear blisters</td>
<td>Moist, weeping</td>
<td>Painful</td>
<td>14–21 days</td>
</tr>
<tr>
<td>thickness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree/deep partial thickness</td>
<td>Pink, hemorrhagic blisters, red</td>
<td>Moist</td>
<td>Painful</td>
<td>Weeks, may progress to 3rd degree and require graft, may lead to contractures</td>
</tr>
<tr>
<td>3rd degree/full thickness</td>
<td>White, brown, charred</td>
<td>Dry, waxy, leathery</td>
<td>Painless</td>
<td>Requires excision, high risk for infection/fluid loss</td>
</tr>
<tr>
<td>4th degree (tendon, nerve, muscle, bone and/or deep fascia involvement)</td>
<td>Brown, charred</td>
<td>Dry</td>
<td>Painless</td>
<td>Requires excision, high risk for infection/fluid loss</td>
</tr>
</tbody>
</table>
## ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS

### Lund & Browder Chart

#### BURN DIAGRAM, ESTIMATE

(Lund & Browder)

<table>
<thead>
<tr>
<th>AREA</th>
<th>Infant</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15</th>
<th>adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>head</td>
<td>10</td>
<td>17</td>
<td>13</td>
<td>11</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>neck</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>ant. trunk</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>post. trunk</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>r. buttock</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
</tr>
<tr>
<td>l. buttock</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
</tr>
<tr>
<td>genitalia</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>r. u. arm</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>l. u. arm</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>r. l. arm</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>l. l. arm</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>r. hand</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
</tr>
<tr>
<td>l. hand</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
<td>2 1/2</td>
</tr>
<tr>
<td>r. thigh</td>
<td>5 1/2</td>
<td>6 1/2</td>
<td>8</td>
<td>8 1/2</td>
<td>9</td>
<td>9 1/2</td>
</tr>
<tr>
<td>l. thigh</td>
<td>5 1/2</td>
<td>6 1/2</td>
<td>8</td>
<td>8 1/2</td>
<td>9</td>
<td>9 1/2</td>
</tr>
<tr>
<td>r. leg</td>
<td>5</td>
<td>5</td>
<td>5 1/2</td>
<td>6</td>
<td>6 1/2</td>
<td>7</td>
</tr>
<tr>
<td>l. leg</td>
<td>5</td>
<td>5</td>
<td>5 1/2</td>
<td>6</td>
<td>6 1/2</td>
<td>7</td>
</tr>
<tr>
<td>r. foot</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
</tr>
<tr>
<td>l. foot</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
<td>3 1/2</td>
</tr>
</tbody>
</table>

#### BURN ASSESSMENT

<table>
<thead>
<tr>
<th>PARTIAL THICKNESS</th>
<th>FULL THICKNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

---

**BURN ASSESSMENT:**

Date ____________  Time ____________  Signature ____________

---

Last updated: 2014
### Rule of 9’s Charts:

#### BURN DIAGRAM ESTIMATE
(Rule of 9’s: Estimate of TBSA – Total Burn Surface Area)

![Infant](image1)

![Child](image2)

![Adult](image3)

<table>
<thead>
<tr>
<th>Area</th>
<th>Infant</th>
<th>Child</th>
<th>Adult</th>
<th>Burn Assessment</th>
<th>Partial thickness</th>
<th>Full thickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>9</td>
<td>14</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest (Ant. torse)</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back (Post. Torse)</td>
<td>13</td>
<td>18</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axilli &amp; Breasts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rt. arm &amp; hand</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lt. arm &amp; hand</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rt. Leg 6 foot (anterior)</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lt. Leg 6 foot (anterior)</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rt. Leg 6 foot (anterior)</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pernium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

*Bolded areas = nine or multiple of nine*

**Burn Assessment**
Date:______
Time:_____
Signature:___________________

---

Last updated: 2014
ATTACHMENT 14: PEDIATRIC BURN PROTOCOLS

Nutritional Algorithm for Burn Patients

Adult and Pediatric: < 20% TBSA Burn

Age appropriate diet
2 day calorie count
Nutritional supplements
Multivitamin with minerals

Conscious sedation or twice daily wound care or inadequate calorie counts (<85%)?

YES

Place postpyloric feeding tube
Confirm with abdominal X-ray
If unable to place after 2 bedside attempts, obtain GI consult for placement under fluoroscopy or with interventional radiology.

NO

Continue current regimen.

1-10 year old
Infuse at 1 cal/mL of high calorie pediatric formula @ 20 mL/hr.
Increase by 10 mL/hr every 6 hours.
Goal is 40 mL/hr.

11-17 year old
Infuse at 1.5 cal/mL high calorie formula @ 20 mL/hr.
Increase by 10 mL/hr every 6 hours.
Goal is 60 mL/hr.

≥ 18 years old
Infuse high protein, high calorie formula @ 30 mL/hr.
Increase by 25 mL/hr every 6 hours.
Goal of 80 mL/hr.

NO

If unable to place postpyloric feeding tube after 2 bedside attempts, place feeding tube in stomach
Confirm with abdominal X-ray.
Start gastric feedings.
HOB > 30 degrees.
Reassess for indications for postpyloric feedings.

If patient has a NG tube for feedings, check residuals every 4 hours.

Residuals <300 mL/4 hours

Continue tube feedings as ordered.

Residual >300 mL/4 hours

Notify physician.
Stop tube feeding x 4 hours.
Restart tube feeding and advance as tolerated (e.g., no nausea, vomiting or residuals >300 mL/4 hours).
If residual >300 mL/4 hr x 2, consider postpyloric placement.
Common Pediatric Inpatient Treatment and Monitoring Interventions

**INTERVENTION**

**Vital Signs:**
- Vital signs at least every 4 hours (T, HR, RR)
- BP every 8 hours, if stable
- Pulse oximetry if on O₂
  - Continuous preferred
  - At least every 4 hour checks
- HR may be continuously monitored via pulse oximetry

**PEDiATRIC CAVEATS/RATIONALE**

**Vital Signs:**
- Vital signs vary greatly with age:

<table>
<thead>
<tr>
<th>Age</th>
<th>Average HR (beats/min)</th>
<th>Average RR (breaths/min)</th>
<th>Average Systolic BP (mm/Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn 0-1 month</td>
<td>100-180</td>
<td>30-60</td>
<td>&gt;60</td>
</tr>
<tr>
<td>Infant 1-12 months</td>
<td>100-160</td>
<td>30-60</td>
<td>&gt;70</td>
</tr>
<tr>
<td>Toddler 1-3 years</td>
<td>90-150</td>
<td>24-40</td>
<td>&gt;70</td>
</tr>
<tr>
<td>Pre-School Age 3-5 years</td>
<td>80-140</td>
<td>22-34</td>
<td>&gt;75</td>
</tr>
<tr>
<td>School Age 5-11 years</td>
<td>70-120</td>
<td>18-30</td>
<td>&gt;80</td>
</tr>
<tr>
<td>Adolescent 13-18 years</td>
<td>60-100</td>
<td>12-16</td>
<td>&gt;90</td>
</tr>
</tbody>
</table>

- Best predictors of shock:
  - Tachycardia is first sign of shock
  - Altered mental status
  - Low urine output
  - Capillary refill (not well-validated)
- Infants can’t increase cardiac stroke volume, thus tachycardia early sign of dehydration

**Assessments:**

Illinois EMSC

[www.luhs.org/emsc](http://www.luhs.org/emsc)
- Obtain head circumference on all children under 2 years of age.
  - Compare to normal for age
  - See: CDC Grow Charts: http://www.cdc.gov/growthcharts
  - If head injury present, obtain measurements daily
- Assess patient’s fontanels on all children under the age of 12 months.
- Obtain abdominal circumference on all abdominal trauma patients
  - Compare to normal for age
  - Obtain measurements daily
- Obtain daily weight (kilograms only)
- Bedside glucose check on all infants who are cold and tachypneic or children with altered mental status.
- PEWS (Pediatric Early Warning Score)
  - Complete every 4 hours or more often as indicated on card

<table>
<thead>
<tr>
<th>Obtain head circumference on all children under 2 years of age.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Compare to normal for age</td>
</tr>
<tr>
<td>- See: CDC Grow Charts: <a href="http://www.cdc.gov/growthcharts">http://www.cdc.gov/growthcharts</a></td>
</tr>
<tr>
<td>- If head injury present, obtain measurements daily</td>
</tr>
<tr>
<td>Assess patient’s fontanels on all children under the age of 12 months.</td>
</tr>
<tr>
<td>Obtain abdominal circumference on all abdominal trauma patients</td>
</tr>
<tr>
<td>- Compare to normal for age</td>
</tr>
<tr>
<td>- Obtain measurements daily</td>
</tr>
<tr>
<td>Obtain daily weight (kilograms only)</td>
</tr>
<tr>
<td>Bedside glucose check on all infants who are cold and tachypneic or children with altered mental status.</td>
</tr>
<tr>
<td>PEWS (Pediatric Early Warning Score)</td>
</tr>
<tr>
<td>- Complete every 4 hours or more often as indicated on card</td>
</tr>
</tbody>
</table>

- Head circumference is an important measurement to determine swelling in the absence of more sophisticated monitoring options.
- Abdominal circumference is an important measurement to determine pathological changes within the abdomen.
- Fontanels:
  - Assess when infant is not crying
  - Anterior fontanel closes at 12-18 months old
  - Posterior fontanel closes within first 3 months
  - Fontanels should be flat, not depressed or bulging
    - Bulging, firm, tense: sign of increased intracranial pressure
    - Sunken, depressed: sign of dehydration
- Hypoglycemia in children:
  - Infants are at high risk of hypoglycemia when cold or stressed
  - Hypoglycemia:
    - < 60 mg/dL in an infant and child (source: PALS)
    - <50 mg/dL in a neonate (source: STABLE)
  - See Treatment: Medication section for dextrose dosing for hypoglycemia
- PEWS Score:
  - Can help nurses assess pediatric patients objectively
  - Using vital signs, child's behavior, cardiovascular and respiratory symptoms
Pain:
- Need to use age/developmental appropriate pain scales
- Examples:
  - Faces Scale for children > 3 years old
  - FLAAC Scale for children < 3 years old

Comfort measures
- Oral glucose drops effective for neonates
- Distract with favorite media, games

Pain:
Wong-Baker Pain Rating Scale:
**FLACC Pain Scale:**

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant frown, clenched jaws, quivering chin</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid, or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans, whimpers, occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

- Developmentally delayed children may have exaggerated CNS depression with opiates
  - Start with lowest dose and titrate

**Intake/Output:**

**Diet/Nutrition**
- Age appropriate diet as tolerated
- Allow to breastfeed as tolerated unless contraindication present

**Intake/Output:**

**Diet/Nutrition**
- Check with parents about diet/formula needs.
- Contraindications to breastfeeding:
  - Mothers who are/have:
    - +HIV
    - Active untreated TB
    - Radioactive milk
    - Using street drugs
    - Herpes simplex lesions on breasts
    - Taking anti-metabolites or chemotherapeutic agents, and small number of other medications until they clear from the milk

- Age appropriate diet as tolerated
- Allow to breastfeed as tolerated unless contraindication present

- Check with parents about diet/formula needs.
- Contraindications to breastfeeding:
  - Mothers who are/have:
    - +HIV
    - Active untreated TB
    - Radioactive milk
    - Using street drugs
    - Herpes simplex lesions on breasts
    - Taking anti-metabolites or chemotherapeutic agents, and small number of other medications until they clear from the milk
- **Age appropriate diet:**
  - **Newborn:**
    - Breast or bottle fed, 2-3 ounces/feeding every 2-3 hours
  - **Infants:**
    - 2-4 months:
      - Breast or bottle fed only, 3-4 ounces/feeding every 3-4 hours
    - 4-6 months:
      - 4-5 ounces/feeding (breast or bottle) 4 times/day
      - Begin baby food (i.e. rice cereal)
    - 6-9 months:
      - 6-8 ounces/feeding (breast or bottle) 4 times/day
      - Baby food and mashed table food
    - 9-12 months:
      - 6-8 ounces/feeding (breast or bottle) 4 times /day
      - Soft bite-sized pieces of food
  - **Toddlers:**
    - Table food is appropriate
    - Soft bite-sized pieces: Avoid foods that can cause choking (i.e. hot dogs, grapes, chunks of meat)
  - **Preschool:**
    - Regular table food is appropriate
    - Soft bite-sized pieces: Avoid foods that can cause choking (i.e. hot dogs, grapes, chunks of meat)
  - **School age and adolescent:**
    - Regular table food is appropriate
  - **Insertion technique for NG/OG is similar to adults.**
    - Measure the length needed by placing the tip of the catheter at the nose, hold the tube at the earlobe and measure to the xiphoid process. Place a small piece of tape at that measurement to guide your placement depth. Lubricate the tube well. Abdominal x-ray should be done to confirm placement.

- Nasogastric / Orogastric tube placement may be needed to decompress the stomach of air after resuscitation or for feedings.
**Urine Output:**
- Assess urine output
  - Place indwelling urinary catheter if needed.
  - Weigh diapers if strict I/O is required

<table>
<thead>
<tr>
<th>OG/NG Tube Size Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
</tr>
<tr>
<td>Child</td>
</tr>
</tbody>
</table>

**Urine Output:**
- Normal urine output is at least 1 mL/kg/hr
- For catheter placement, use similar technique as with adult placement.

<table>
<thead>
<tr>
<th>Urinary Catheter Size Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn/Infant</td>
</tr>
<tr>
<td>Toddler/Preschool</td>
</tr>
<tr>
<td>School Age</td>
</tr>
<tr>
<td>Adolescent</td>
</tr>
</tbody>
</table>
- To weigh diapers:
  - Subtract total weight from dry diaper weight
  - 1 gm = 1 mL urine

**IV Fluids:**

**IV Site selection:**
- Infants (< 12 months): hand, wrist, antecubital, saphenous, feet, scalp
- >12 months: hand, wrist, antecubital

<table>
<thead>
<tr>
<th>Suggested IV Catheter Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborns/Infants</td>
</tr>
<tr>
<td>Toddlers/School Age</td>
</tr>
<tr>
<td>Adolescents</td>
</tr>
<tr>
<td>IO Site Selection</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>• Proximal tibia</td>
</tr>
<tr>
<td>• Distal tibia</td>
</tr>
<tr>
<td>• Humerus (if sites palpable)</td>
</tr>
<tr>
<td>• Distal femur (manual IO only)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV/IO Monitoring</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess site at least every 2 hours</td>
<td></td>
</tr>
<tr>
<td>o Ensure you are able to palpate &amp; visualize the site when taping the line</td>
<td></td>
</tr>
<tr>
<td>• Do not wrap tape circumferentially around an extremity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV Fluids: Replacement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Birth -28 days:</td>
<td></td>
</tr>
<tr>
<td>o Bolus 0.9% NS at 10mL/kg</td>
<td></td>
</tr>
<tr>
<td>• &gt; 28 days:</td>
<td></td>
</tr>
<tr>
<td>o Bolus 0.9% NS at 20mL/kg</td>
<td></td>
</tr>
<tr>
<td>• Suspected cardiogenic shock:</td>
<td></td>
</tr>
<tr>
<td>o Bolus 0.9% NS at 5-10mL/kg</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV Fluids: Maintenance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• D5 0.45% NS is standard</td>
<td></td>
</tr>
<tr>
<td>• Add 20mEqKCl/Liter if not hyperkalemic</td>
<td></td>
</tr>
<tr>
<td>• Monitor weight, urine output and</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV/IO Monitoring:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• IV/IO can infiltrate quickly because of the child’s activity. Careful assessment will minimize infiltrate damage</td>
<td></td>
</tr>
<tr>
<td>• Wrapping tape circumferentially around an extremity may cause tissue damage if the IV infiltrates</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV Fluids: Replacement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 0.9% NS Bolus used for fluid replacement or for intravascular expansion to treat shock</td>
<td></td>
</tr>
<tr>
<td>• May use Lactate Ringers if acidotic</td>
<td></td>
</tr>
<tr>
<td>• Administer as rapidly as possible without sacrificing IV/IO</td>
<td></td>
</tr>
<tr>
<td>• May repeat x 3 if for severe dehydration or non-cardiogenic shock</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV Fluids: Maintenance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintenance fluids usually contain D5</td>
<td></td>
</tr>
<tr>
<td>o Provides 17 calories/100 mL and nearly 20% of the daily caloric needs which will prevent ketone production and helps minimize protein degradation</td>
<td></td>
</tr>
<tr>
<td>• Will lose weight on this regimen if enteral feedings not given also</td>
<td></td>
</tr>
</tbody>
</table>
electrolytes and adjust rate/composition of IV fluids accordingly

- To calculate maintenance rate:
  - Birth-28 days: 80-100mL/kg/24hrs
  - >28days:
    - First 10 kg = 4 mL/kg/hr
    - Second 10 kg = 2 mL/kg/hr
    - Each additional kg = 1 mL/kg/hr

- Need to be started on total parental nutrition after a few days of maintenance fluids if enteral feedings are still not possible. (Nelsons, 2011)
  - Potassium should only be added after renal function is proven to be adequate and patient has voided
  - Example 23kg child:
    - First 10 kg = 4 mL/hr x 10kg +
    - Second 10 kg = 2 mL/hr x 10kg +
    - Each additional kg = 1 mL/hr x 3kg = 63mL/hr

Safety:
- Ensure crib rails are up at all times when patient is not directly attended to by a caregiver/parent
- No extra supplies should be kept in the crib or in reach
- Place infant on their back when sleeping
- Children under 3 years of age should be placed in a crib

- Infants can easily roll out of the crib and be injured.
- Supplies may be a choking hazard.
- Infants sleeping on the back decreases the risk of SIDS
- A hospital is not “child proof.” Even if a toddler sleeps in a youth or regular bed at home, consider placing them in a crib for their safety.

Treatments:
**Medications**

**Analgesics**
- Acetaminophen
  - 15mg/kg PO/PR q4hr PRN (max dose in 24 hours=3gms)

- Advantages
  - Minimal adverse effects on GI tract or renal function

- Disadvantages
  - Liver toxicity
<table>
<thead>
<tr>
<th>Medication</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen (infant/child &gt; 6 months)</td>
<td>- Inhibits prostaglandin-induced nociception</td>
<td>- May have limited effect on the immediate treatment of acute pain as these agents do not directly block nociceptors. Inactive against already released inflammatory mediators. Side effects include nausea, vomiting, ulcers, platelet dysfunction, liver toxicity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine + Tylenol (Tylenol #3) (for children &gt; 2 y/o only)</td>
<td>- Rapid onset action, minimal respiratory depression orally</td>
<td>- Nausea, vomiting, constipation, respiratory depression, hypotension, bradycardia, CNS depression, ineffective in 1/3 of patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketorolac (Toradol)</td>
<td>- Effective alternative to opioids for treatment of moderate to severe pain. Can be combined with acetaminophen or low-dose opioids for greater analgesia</td>
<td>- Bleeding diathesis, hyperkalemia and depression of renal function, hepatotoxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>- Moderately rapid predictable onset. Significant role for patients who need prolonged pain control (e.g., fracture reduction, multiple trauma, sickle cell disease)</td>
<td>- Respiratory depression, hypotension, bradycardia, CNS depression, Avoid patients with renal failure.</td>
</tr>
</tbody>
</table>
**Antibiotics**

**Children > 28 days**
- **Ceftriaxone**
  - 75mg/kg IV/IO q24hr
  - Not for infants < 1 m/o
- **Clindamycin**
  - 10mg/kg IV/IO q6hr
- **Vancomycin**
  - 15mg/kg IV/IO q6hr
- **Piperacillin/Tazobactam**
  - 75mg/kg IV/IO q6hr

**Neonates (birth-28 days)**
- **Ampicillin** 100 mg/kg/day IV/IO divided every 6 hours
- **Cefuroxime** 200 mg/kg/day IV/IO divided every 6 hours
- **Acyclovir**

**Fentanyl**
- 1-2mcg/kg/dose IM/IV/IO, IN* q 30-60 minutes PRN
  *For IN route, divide dose equally between each nostril

- Monitor for respiratory depression

**Fentanyl:**
- **Advantages**
  - Rapid onset if given IV/IO, short duration, potent analgesic, better safety
  - Profile for renal patients, preferred medication for renal patients
- **Disadvantages**
  - Respiratory depression, apnea may precede alteration of consciousness chest wall rigidity if given too rapidly.
  - IN route should not be used with facial trauma due to ineffective absorption.

**Antibiotics**
- **Ceftriaxone**
  - Effective for: UTI, pneumonia, bacteremia
  - For CNS infections, dose is 100mg/kg q24hrs and Vancomycin should be added
- **Clindamycin**
  - Treats most skin/soft tissue infections
- **Vancomycin**
  - Reserve for severe infections
  - Good for pneumonia with suspected MRSA or resistant *Pneumococcus*
  - Severe skin/soft tissue infections
  - Gram-positive bacteremia
- **Piperacillin/Tazobactam**
  - Intra-abdominal infections
### Inpatient Treatment and Monitoring Intervention Care Guideline

#### Antimicrobials
- **Gentamicin**: 2.5 mg/kg IV/IO every 8 hours.
- **Amoxicillin**: 40 mg/kg/day divided every 12 hours.
- **Ceftriaxone**: 60 mg/kg/day divided every 8 hours.

#### Antivirals
- **Oseltamivir**: 2 weeks - 1 year (Use for treatment only):
  - 3 mg/kg/dose q 12 hours x 5 days
- > 1 yr (Use for treatment and prophylaxis): 3 mg/kg q 12 hours x 5 days
- **Acyclovir**: < 12 y: 20 mg/kg IV/IO q8h
- > 12 y: 10 mg/kg IV/IO q8hr

#### Dextrose
- Dextrose 0.5-1 g/kg IV/IO
- D50W: 1-2 mL/kg IV/IO
- D25W: 2-4 mL/kg IV/IO
- D10W: 5-10 mL/kg IV/IO (infants > 28 days)
- D10W: 2 mL/kg IV/IO (birth - 28 days)

#### Antivirals:
- **Oseltamivir**: Recommended by CDC for hospitalized patients with influenza
- **Acyclovir**: Usually reserved for CNS infections

#### Dextrose:
- Maximum recommended concentration for a bolus administration in children > 28 days for hypoglycemia is D25W
- Maximum recommended concentration for a bolus administration in neonates for hypoglycemia is D10W
- To convert D50W to D10W:
  - Mix 1 part D50W to 4 parts sterile water or normal saline
### To convert D50W to D25W

- Mix 1 part D50W to 1 part sterile water or normal saline

### Other Treatments:

#### Blood Administration:
- Replacement with PRBC/Platelet/Albumin 5%/FFP = 10mL/kg
- Assess the child frequently throughout the infusion for a possible transfusion reaction

### Other Considerations:

#### Children with Special Health Care Needs:
- Tracheostomy Care (established tracheostomy)
- G-Tube or J-Tube (established)

The parent of a child with special needs will be your best reference for how to manage their care. They will be willing to share their treatment plan and techniques. Some parents will have a resource binder or other reference with them.

- Tracheostomy Care: Similar care to adults, wash site gently with warm water as needed. Change tracheostomy ties daily and as needed.
- G-Tube/J-Tube: Similar care to adults, wash site gently with warm water as needed. If tube is accidentally dislodged and a replacement tube is not readily available, you may replace with an indwelling urinary catheter. Slide the catheter in gently. There should be minimal resistance.

Resource: EMSC CSCHN Reference Guide
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster. This form is to be filled out by the initial hospital and sent with the patient (either when discharged home or to another facility) to communicate what initial management has been completed.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

In a disaster scenario, normal routine newborn care may be inadvertently delayed. Therefore, an evaluation of the newborn by a health care provider with expertise in the care of a newborn (e.g., pediatrician, family practice physician, or pediatric nurse practitioner) should occur as soon as possible. The form below and information found in this care guideline is provided to assist those hospitals who typically do not care for newborns to provide necessary care until the above experts can evaluate the patient.

<table>
<thead>
<tr>
<th>PHYSICAL EXAM</th>
<th>YES</th>
<th>NO</th>
<th>ISSUE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam WNL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL FUNCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital signs WNL</td>
</tr>
<tr>
<td>See attached for normal values</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulse ox screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Age of child _____</td>
</tr>
<tr>
<td>□ Right hand SpO₂% _____</td>
</tr>
<tr>
<td>□ Left or Right Foot SpO₂% _____</td>
</tr>
</tbody>
</table>

Any medical problems?

Anomaly present

Feeding assessment
| □ Breastfeeding |
| □ Bottle feeding |

Voiding

Stooling
| □ Birth weight ______ |
| □ Current weight________ |

Weight loss >7%

Jaundice absent

Signs or concerns for infection

Normal hearing screening

<table>
<thead>
<tr>
<th>LAB RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal</td>
</tr>
<tr>
<td>□ Blood type/Rh _____</td>
</tr>
<tr>
<td>□ Group B streptococcus _____</td>
</tr>
<tr>
<td>□ Other (i.e. HIV)______</td>
</tr>
</tbody>
</table>

Newborn
| □ Blood type/Rh_____ |
| □ Glucose _____ |
| □ Hematocrit _____ |
| □ Bilirubin _____ |
| □ Phenylketonuria (PKU)______ |
| □ HIV if mother’s status is unknown |
| □ Other_____ |

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Vitamin K</td>
</tr>
<tr>
<td>Dose given: Route:</td>
</tr>
<tr>
<td>Eye prophylaxis</td>
</tr>
<tr>
<td>Medication used:</td>
</tr>
</tbody>
</table>
Newborns are one of the most vulnerable population groups. Hand hygiene is essential. Breastfeeding is the gold standard. Keep mother and baby together.

**Care of Newborn after Delivery in Transition Period (0-8 hours)**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>CAVEATS/RATIONALE</th>
</tr>
</thead>
</table>
| Dry baby immediately with a towel and then gently suction mouth and nose. | Sample APGAR Score Card

**INTERVENTION**

- Calculate APGAR Scores:
  - Perform at 1 and 5 minutes.
  - Repeat APGAR scores every 5 minutes for 20 minutes or until Apgar score ≥ 7.
  - If child is stable with a pink core and a 5-minute APGAR score >7, then rewrap the baby in clean, warm, dry blankets and allow parents to hold baby.

**CAVEATS/RATIONALE**

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Blue</td>
<td>Pink body, blue extremities</td>
<td>All pink</td>
</tr>
<tr>
<td>Pulse</td>
<td>Absent</td>
<td>&lt;100</td>
<td>&gt;100</td>
</tr>
<tr>
<td>Grimace</td>
<td>No response</td>
<td>Weak cry and grimace</td>
<td>Vigorous cry</td>
</tr>
<tr>
<td>Activity</td>
<td>Flaccid, limp</td>
<td>Some flexion</td>
<td>Active motion</td>
</tr>
<tr>
<td>Respirations</td>
<td>Absent</td>
<td>Slow, irregular</td>
<td>Good, vigorous cry</td>
</tr>
</tbody>
</table>

**At 15 minutes old assess:**

- Overall condition
- Respiratory status
- Cardiovascular status
- Skin color
- Muscle tone

**Respiratory Status:**

- Respiratory rate: 30-60 breaths/minute
- May have coarse rales until amniotic fluid is cleared from infant’s lungs
- Grunting and retractions may occur until amniotic fluid is cleared from infant’s lungs but these should resolve within an hour
- Abnormal:
| **Temperature** | Apnea lasting longer than 20 seconds  
 Persistent central cyanosis  
 O$_2$ <85% in room air  
 Needing supplemental O$_2$ after 2 hours of age  
 Excessive oral mucus  
 Drooling  
 Periods of cyanosis  
 Choking or coughing episodes |
|---|---|
| **Cardiovascular Status:** | **Heart rate:** 120-160 bpm. Heart rate may fall to 80 bpm, but without changes in color or respirations  
 **Murmurs can be normal**  
 **Abnormal:**  
 Persistent bradycardia  
 Capillary refill > 3 seconds and unstable blood pressures may indicate: hypoxia, sepsis, CNS injury, or other cardiovascular problems |
| **Neurological/Muscle Tone:** | **Abnormal:**  
 Listlessness  
 Lethargy  
 Hypotonia  
 Irritability  
 Excessive tremors  
 Jitteriness |
| **Skin color:** | **Abnormal:**  
 Persistent pallor in the post-partum period may indicate anemia, cardiovascular collapse, or intra-partum asphyxia |
| **Temperature:** | Temperature may fall to 36.5°C (97.7°F) at the mean age of 75 minutes old  
 Do not bathe the baby until the temperature is stable between 36.5°-37.0°C (97.7°-98.0°F) |
| Check axillary temperature every 30-60 minutes during transition | Infant skin-to-skin contact with mother keeps the baby warm  
 If using a radiant warmer then must compare infant’s temperature against the radiant warmer |
Perform glucose screen if newborn is high risk or symptomatic

- Newborns have limited glycogen stores which are rapidly depleted during times of stress.
- Hypoglycemia is < 50mg/dL
  - This value is based on the STABLE recommendation and is typically used for high risk newborns. PALS and NRP have other values listed as their definition of hypoglycemia (45 and 40, respectively).
- High Risk:
  - Premature
  - Small for gestation age
  - Mothers who were diabetic
  - Any newborn looking ill
- Symptoms:
  - Irritability, tremors, jitteriness, seizures
  - Abnormal high pitch cry
  - Exaggerated Moro reflex
    - Definition of Moro reflex: In response to loss of balance, newborns arch their back, flings their arms outwards, extends the legs, and opens the hands, after which they slowly returns to a flexed position
  - Lethargy, limpness, hypotonia
  - Cyanosis, apnea, irregular respirations
  - Hypothermia, vasomotor instability, temperature instability
  - Poor suck
  - Feeding poorly or refusal to feed when feeding well previously
- Treatment for hypoglycemia:
  - If possible, allow newborn to feed (breast milk or formula)
  - If unable to feed, consider providing pumped breast milk or formula via NG
  - If unable to take PO, administer Dextrose 10% bolus of 2mL/kg
- If hypoglycemia reoccurs or lasts 48-72 hours post-delivery:
  - Could suggest an inborn error of metabolism or some kind of endocrine disorder which necessitates further medical care

Administer eye prophylaxis
- Erythromycin 0.5% ointment OR
- Silver nitrate 1% solution OR
- Tetracycline 1% ointment

- Illinois State mandate
- Best given within 1st hour of delivery

Administer Vitamin K
- Infant weight < 1.5 kg: 0.5mg IM as a single dose
- Give within 1 hour of birth
- Given to prevent Vitamin K Deficiency Bleeding (aka “Hemorrhagic Disease of the Newborn”)
### Newborn Complications:

<table>
<thead>
<tr>
<th>Infant weight &gt; 1.5 kg: 1.0mg IM as a single dose</th>
</tr>
</thead>
</table>

#### Hyperbilirubinemia:
- Bilirubin should be checked in a newborn that is jaundiced before 24 hours of age

- Sepsis:
- Other potential interventions depending on presenting symptoms:
  - Oxygen administration
  - Suctioning as needed
  - Normothermic environment
  - Bedside glucose
  - Pulse oximetry reading in right arm compared against any other extremity
  - Frequent monitoring
  - Chest X-ray
  - Echocardiogram
  - Exogenous surfactant fluid replacement therapy
  - Mechanical ventilation
  - Antibiotic coverage
  - IV nutrition if respiratory distress interferes with feeding

#### Hyperbilirubinemia:
- Common causes:
  - Breast-feeding-associated jaundice
  - ABO & Rh incompatibility
  - Polycythemia
  - Bruising of the newborn (e.g., cephalhematoma)
  - Bowel obstruction
  - Inborn errors of metabolism
  - G6PD deficiency
- Treatment for breast-feeding-associated jaundice:
  - Promote frequent breastfeeding (minimal 8-10 times/day)
  - Have mother pump her breasts after feeding
  - Avoid pacifiers
  - Avoid supplementation unless medically indicated (excessive weight loss or hypoglycemic).
  - Expressed breast milk or formula is preferred
- Other treatment includes phototherapy requiring qualified personnel

#### Sepsis:
- Symptoms may include:
  - Apnea
  - Respiratory distress
  - Poor activity
  - Poor feeding
  - Hypothermic
  - Poor color
- Risk factors include:
  - Maternal group B streptococcus
  - Premature rupture of membranes
  - Mother with intrapartum fever
  - Chorioamnionitis

### Feeding:
- Promote breastfeeding within 30-60 minutes after delivery
  - Feed every 2-3 hours so at least

- Early and exclusive breastfeeding is best for normal term, healthy neonates and prevents hypoglycemia
- Contraindications to breastfeeding:
  - Mothers who are/have:
    - +HIV
8 to 12 feedings occur every 24 hours
- Bottle feed when breastfeeding or pumped breast milk not possible
  - 2-3 oz. of formula per feeding every 2-3 hours
- Active untreated TB
- Radioactive milk
- Using street drugs
- Herpes simplex lesions on breasts
- Taking anti-metabolites or chemotherapeutic agents, and small number of other medications until they clear from the milk

**Caring for Newborns After Delivery (8-96 hours)**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>CAVEATE/RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs:</strong></td>
<td><strong>Vital Signs:</strong></td>
</tr>
<tr>
<td>• Obtain vital signs every 8 hours</td>
<td>• RR:</td>
</tr>
<tr>
<td>- RR: count for full minute</td>
<td>- Normal respirations: 30-60 breaths/minute</td>
</tr>
<tr>
<td>- HR: auscultate apical pulse for full minute</td>
<td>- Respiratory distress includes:</td>
</tr>
<tr>
<td>- Pulse oximetry screening: perform when at least 24 hours old</td>
<td>- Grunting</td>
</tr>
<tr>
<td>- BP: not recommended if well newborn</td>
<td>- Nasal flaring</td>
</tr>
<tr>
<td>- Temperature</td>
<td>- Retractions</td>
</tr>
<tr>
<td></td>
<td>- Cyanosis</td>
</tr>
<tr>
<td></td>
<td>- Tachypnea</td>
</tr>
<tr>
<td></td>
<td>- Apnea</td>
</tr>
<tr>
<td></td>
<td>- Hypoxemia</td>
</tr>
<tr>
<td></td>
<td>• Abnormal:</td>
</tr>
<tr>
<td></td>
<td>- Apnea &gt; 15 seconds may indicate:</td>
</tr>
<tr>
<td></td>
<td>- Sepsis</td>
</tr>
<tr>
<td></td>
<td>- Maternal drugs/medications</td>
</tr>
<tr>
<td></td>
<td>- Hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>- Anemia</td>
</tr>
<tr>
<td></td>
<td>- Other metabolic abnormality</td>
</tr>
<tr>
<td></td>
<td>- Tachypnea &gt; 60 breaths/minute may indicate a respiratory, cardiovascular or metabolic problem</td>
</tr>
</tbody>
</table>
• **HR:**
  - Normal heart rate: 80-160 bpm (slower when sleeping and faster when crying)
  - **Abnormal:**
    - Symptoms of cardiovascular compromise may include:
      - Tachycardia
      - Unequal pulses or blood pressures
      - Poor pulses
      - Respiratory distress
      - Cyanosis of face
      - Central cyanosis
      - Hepatomegaly
    - Abnormal heart rate (80 < bpm > 180) may indicate:
      - Sepsis
      - Asphyxia
      - Hypoxemia
      - Heart block
      - Anemia
      - Hypovolemia
      - Sepsis

• **Pulse oximetry screening:**
  - Normal is at least ≥ 95% in either extremity with a ≤ 3% absolute difference between upper and lower extremity.
  - Must use right hand (preductal) and on one foot (post-ductal)
  - SpO₂ < 90% require an expert evaluation to test for infectious and pulmonary causes and for ruling out critical congenital heart disease.
  - High altitudes may result in false positives.

• **Temperature:**
  - Normal axillary temperature: 36.5°-37°C (97.9°-98.3°F)
  - If not normothermic must consider causes:
    - Environmental
    - Sepsis
    - Postasphyxial insult
    - Low brown fat stores
    - Prematurity
    - Small for gestational age (SGA)
<table>
<thead>
<tr>
<th>Diet/Feeding:</th>
<th>Diet/Feeding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Breastfeeding:</td>
<td>• General:</td>
</tr>
<tr>
<td>o Every 2-3 hours so at least 8 to 12 feedings occur every 24 hours</td>
<td>o Early signs of hunger:</td>
</tr>
<tr>
<td>• Bottle feeding:</td>
<td>▪ Increased alertness</td>
</tr>
<tr>
<td>o 2-3 oz of formula per feeding every 2-3 hours</td>
<td>▪ Physical activity</td>
</tr>
<tr>
<td></td>
<td>▪ Mouthing or rooting</td>
</tr>
<tr>
<td></td>
<td>o Late sign of hunger</td>
</tr>
<tr>
<td></td>
<td>▪ Crying</td>
</tr>
<tr>
<td></td>
<td>• Burping:</td>
</tr>
<tr>
<td></td>
<td>o Attempted when newborn has ingested 0.5 to 1 ounce of formula and at the end of every feeding</td>
</tr>
<tr>
<td></td>
<td>o Ensure airway is maintained and the head and trunk are supported</td>
</tr>
<tr>
<td></td>
<td>o Gently rub or pat from the lower back in an upwards motion with the newborn sits with support on the caregiver's lap or while being held upright against a caregiver's chest</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding:</td>
</tr>
<tr>
<td></td>
<td>o Preferred choice even during disasters</td>
</tr>
<tr>
<td></td>
<td>o Feedings should last about 10-15 minutes of active suck on each breast</td>
</tr>
<tr>
<td></td>
<td>o Alternate starting breast at each feeding</td>
</tr>
<tr>
<td></td>
<td>o May need to wake up for feedings especially if it has been four hours since the last feeding</td>
</tr>
<tr>
<td></td>
<td>o Do not interrupt breastfeeding</td>
</tr>
<tr>
<td></td>
<td>o Do not offer any type of supplement feedings unless ordered by a physician</td>
</tr>
<tr>
<td></td>
<td>o Offer pacifier only after breastfeeding has been well established. Otherwise use pacifier only during specific circumstances like pain relief during medical procedures</td>
</tr>
<tr>
<td></td>
<td>• Bottle feeding:</td>
</tr>
<tr>
<td></td>
<td>o Iron-fortified infant formula that is commercially-prepared is the recommended</td>
</tr>
<tr>
<td></td>
<td>o Do not prop the bottle</td>
</tr>
<tr>
<td></td>
<td>▪ Infants must be held in a cuddled position so that the head is slightly above the stomach.</td>
</tr>
<tr>
<td></td>
<td>▪ Position the angle of the bottle to prevent air swallowing.</td>
</tr>
<tr>
<td></td>
<td>▪ Can rub the nipple softly along the lower lip to help open the infant's mouth</td>
</tr>
<tr>
<td></td>
<td>o All feeding supplies should be washed with clean hot soapy water and then rinsed with clean</td>
</tr>
</tbody>
</table>
hot water and allowed to air dry.
- Sterile technique is recommended when there is a problem with the clean water supply, lack of access to refrigeration, or when the newborn has an immune deficiency problem
  - Prepare formula according to manufacturer's recommendations
    - Only prepare bottles with the amount formula that is expected to be consumed in one feeding.
    - Discard unused formula within 1 hour.
    - Bottles can be made in advance and stored in a refrigerator for up to 24 hours.
  - Warming formula:
    - Formula should be warmed to room temperature only
      - Avoid formula that is either cold or too hot
    - Do not warm formula in the microwave.
    - May warm formula by holding the bottle under warm running water.
    - Test the temperature of warmed formula by shaking the bottle first before applying a few drops to the adult's inner wrist
  - Consider placing a nasogastric tube (NG) if newborn is not NPO but is having difficulty feeding or is hypoglycemic and administer either pumped breast milk or formula as indicated above

<table>
<thead>
<tr>
<th>Elimination:</th>
<th>Skin Care/Cord Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Urine output:</td>
<td>- Skin care:</td>
</tr>
<tr>
<td>- First 1-2 days: 2-6 wet diapers/day</td>
<td>- Observe face, trunk, and extremities for cyanosis or jaundice</td>
</tr>
<tr>
<td>- 3-5 days: 3-5 wet diapers/day</td>
<td>- Do not scrub vernix off</td>
</tr>
<tr>
<td>- 5-7 days: 4-6 wet diapers/day</td>
<td>- Scrubbing may damage skin</td>
</tr>
<tr>
<td>- Stool:</td>
<td>- Vernix may offer antibacterial properties</td>
</tr>
<tr>
<td>- First 1-2 days: well newborns pass meconium stool (black, tarry stool).</td>
<td>- Use a gentle soap without perfumes</td>
</tr>
<tr>
<td>- 3-5 days: 3-4 stools/day</td>
<td></td>
</tr>
<tr>
<td>- 5-7 days: 3-6 stools/day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elimination:</th>
<th>Skin Care/Cord Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Staff should notify physician if no urine output for 12 hours</td>
<td>- Clean with every diaper change</td>
</tr>
<tr>
<td>- Routine circumcision not recommended by the AAP</td>
<td>- Clean with every diaper change</td>
</tr>
<tr>
<td>- Do not forcibly retract foreskin</td>
<td>- Clean with every diaper change</td>
</tr>
</tbody>
</table>
| and with sponge baths | • **Cord care:**  
|                       |   o Cord typically falls off in 7-10 days  
|                       |   o Make sure diaper does not cover the cord  
|                       |   o No isopropyl alcohol on cord  
|                       |   o May sponge with warm water on the cord until it falls off  
|                       |   o When the cord has fallen off, may use gentle soap and water  
|                       |   o Do not immerse the baby in bath water until the cord has fallen off  
|                       |   o **Abnormal:**  
|                       |     ▪ Drainage that looks serous, purulent, or sanguineous  
|                       |     ▪ Circumferential redness at base of the cord |
Purpose: To provide guidance to practitioners caring for pregnant women and newborn patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Initial Management of All Obstetrical (OB) Patients

- Stabilize ABCs (Airway, Breathing, Circulation)
- For OB trauma patients, stabilize the patient’s condition and provide treatment according to trauma guidelines before evaluating the fetus. (See pg. 8 for further care). Be aware of the following caveats:
  - Use rapid sequence induction with cricoid pressure and gastric decompression when oral intubation is required
  - Use closed-tube thoracotomy at a higher intercostal space when treating pneumothorax
  - Place patients who are > 20 weeks gestation in the left lateral position, left lateral tilt, right lateral position or right lateral tilt (while maintain spinal precautions as applicable) to maximize venous return
- Triage:
  - Determine:
    - Number of weeks gestation
    - If the presenting complaint due to the pregnancy
    - If the presenting complaint unrelated to the pregnancy but affects the pregnancy
    - If the presenting complaint affects the pregnancy
  - Triage all pregnant women that are >20 weeks gestation based on the level of severity of patient’s complaint related to or that affects the pregnancy to determine level of perinatal services needed:
    - Emergent: (In need of Level III Perinatal Center care) (background read thru for each perinatal center under each section)
      - Cardio-pulmonary failure/arrest
      - Eclampsia
      - Active hemorrhage/heavy bleeding
      - Fetal parts or foreign bodies protruding from vagina
      - Diabetic coma/DKA
      - Altered level of consciousness
      - Multiple gestation (greater than twins) in active labor
      - Active labor in mothers with <30 weeks gestation
      - Laboring mother with known antenatal fetus defect (i.e. cardiac, pediatric surgery)
      - Pre-eclampsia or Hemolysis, Elevated Liver Enzymes, and Low Platelets (HELLP) syndrome
      - Other life threatening conditions to mother or fetus
    - Urgent: (In need of Level II-E Perinatal Center care)
      - Active labor in mothers with >30 and <35 weeks gestation
      - Multiple gestation (no more than twins) in active labor
      - Decreased fetal movement
      - Abdominal pain
      - Preterm rupture of membranes >30 and <35 weeks gestation
      - Obesity
- Non-urgent: (In need of Level I or Level II Perinatal Center care)
  - Active labor in mothers with >35 weeks gestation
  - Preterm rupture of membranes >35 weeks gestation
  - Rule out rupture of membranes (ROM)
  - Stable gestational hypertension
- Perform a complete assessment of pregnant patient at time of presentation (See *Initial Assessment of the Pregnant Patient* for checklist)
- For all OB patients:
  - Establish large bore IV access
  - Obtain lab exams (if available): CBC with differential, Type and RH or Type and Screen, and HIV
  - Obtain prenatal care records (if available)
- Consult Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient (mother and child); to individualize the care of patient; if patient needs to be transferred; and as needed for further support and consult.
Management for Common Life Threatening Obstetrical Conditions

Identifying Preeclampsia and/or Eclampsia

<table>
<thead>
<tr>
<th>ASSESS</th>
<th>NORMAL</th>
<th>MODERATE</th>
<th>SEVERE/ECLAMPSIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>Alert/Oriented</td>
<td>Agitated, confused, drowsy, difficulty speaking</td>
<td>Unresponsive, seizure activity</td>
</tr>
<tr>
<td>Headache</td>
<td>None</td>
<td>Mild headache, nausea, vomiting</td>
<td>Unrelieved headache</td>
</tr>
<tr>
<td>Vision</td>
<td>None</td>
<td>Blurred or impaired</td>
<td>Temporary blindness</td>
</tr>
<tr>
<td>Systolic BP (mmHg)</td>
<td>100-139</td>
<td>140-159</td>
<td>≥160</td>
</tr>
<tr>
<td>Diastolic BP (mmHg)</td>
<td>50-89</td>
<td>90-105</td>
<td>≥105</td>
</tr>
<tr>
<td>Heart rate</td>
<td>61-110</td>
<td>111-129</td>
<td>≥130</td>
</tr>
<tr>
<td>Respiration</td>
<td>11-24</td>
<td>25-30</td>
<td>&lt;10 or &gt;30</td>
</tr>
<tr>
<td>SpO₂ (%)</td>
<td>≥95</td>
<td>91-94</td>
<td>≤90</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>None</td>
<td>Present</td>
<td>Present</td>
</tr>
<tr>
<td>Pain (abdomen or chest)</td>
<td>None</td>
<td>Nausea, vomiting, chest pain, abdominal pain</td>
<td>Nausea, vomiting, chest pain, abdominal pain</td>
</tr>
<tr>
<td>Urine output (mL/hr)</td>
<td>≥50</td>
<td>30-49</td>
<td>≤30 (in 2 hours)</td>
</tr>
<tr>
<td>Proteinuria</td>
<td>Trace</td>
<td>+1, +2, ≥300/24 hours</td>
<td>&gt;+3; ≥5gm/24 hours</td>
</tr>
<tr>
<td>Platelets</td>
<td>&gt;100</td>
<td>50-100</td>
<td>&lt;50</td>
</tr>
<tr>
<td>AST/ALT</td>
<td>&lt;70</td>
<td>&gt;70</td>
<td>&gt;70</td>
</tr>
<tr>
<td>Creatinine</td>
<td>&lt;0.8</td>
<td>0.9-1.2</td>
<td>&gt;1.2</td>
</tr>
<tr>
<td>Magnesium Sulfate Toxicity</td>
<td>DTR +1; Respiration 16-20</td>
<td>Depression of patellar reflexes</td>
<td>Respiration &lt;12</td>
</tr>
</tbody>
</table>

Normal: Monitor patient for changes in condition as per hospital protocol.

Moderate: Consult Pediatric Care Medical Specialist to assist with arranging transfer of patient to higher level perinatal center.

Positive Trigger | Treatment
---|---
1 of any type | Increase assessment frequency, Notify provider
≥ 2 of any type | Order labs/tests, Consider Magnesium Sulfate, Provide supplemental O₂

Severe/Eclampsia:
- Central imaging is not necessary for the diagnosis and management of most with eclampsia but is indicated in patients with focal neurologic deficits or prolonged coma.
- Eclampsia can occur during the antepartum, intrapartum and postpartum period.
- Consult Pediatric Care Medical Specialist to assist with arranging transfer of patient to higher level perinatal center.
- See next page for Treatment.

Illinois EMSC | www.luhs.org/emsc
Treatment of Severe Preeclampsia and/or Eclampsia

**Identify Severe Preeclampsia and/or Eclampsia**

**Respiratory:**
- O₂, 10L via NRB mask
- Chest x-ray r/o pulmonary edema

**Fetal Monitoring**
- Monitor fetal heart rate
- Consider ultrasound

**Fluid balance:**
- IVF maintenance rate of 83mL/hr
- Place a urinary catheter to monitor urine output hourly

**Seizure treatment/prophylaxis**
- Magnesium sulfate bolus (6g) IV/IO over 15-20 minutes followed by magnesium sulfate infusion (1-2g/hr) IV/IO. Monitor for respirator depression and maintain urine output ≥100mL/3 hours.
- Recurrent seizures: Magnesium sulfate 2gm IV/IO; check magnesium level

**Hypertension**
- Target BP= 140-150/80-90
- Treat when SBP ≥160 and/or DBP ≥110
  - **Labetalol:**
    - Contraindications: asthma, COPD, Bradycardia, and/or heart block.
    - 20 mg IV/IO bolus. If no improvement after 15 minutes, give 40mg IV/IO. If no improvement after 15 minutes give 80mg IV/IO. If no improvement after 15 minutes, repeat 80mg IV/IO. Max is 300mg in 24 hours AND/OR
  - **Hydralazine:**
    - 5mg IV/IO Bolus over 2-4 minutes. If no improvement, repeat in 20 minutes. If no improvement, 10mg IV/IO every 20 minutes for a MAXIMUM dose of 40mg in a 24 hour period. Monitor vital signs immediately after and every 5 minutes during administration.

**Thromboembolism**
- Apply compression stockings
- Consider heparin

**Plan for delivery:**
- Route: Vaginal preferred over cesarean
- Plan for transfer to Level III Perinatal Center

Prevent maternal injury and support ABCs
Implement monitoring: 1:1 staff ratio

Illinois EMSC www.luhs.org/emsc
### Maternal Hemorrhage: Recognition and Treatment

<table>
<thead>
<tr>
<th></th>
<th>Class I</th>
<th>Class II</th>
<th>Class III</th>
<th>Class IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. Blood Loss (EBL)*</td>
<td>~ 900 mL</td>
<td>~ 1200-1500 mL</td>
<td>~ 1800-2100 mL</td>
<td>&gt; ~ 2400 mL</td>
</tr>
<tr>
<td>Pulse</td>
<td>&lt;100</td>
<td>&gt; 100</td>
<td>&gt; 120</td>
<td>&gt; 140</td>
</tr>
<tr>
<td>Respiration</td>
<td>14-20</td>
<td>20-30</td>
<td>30-40</td>
<td>&gt; 35</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Normal</td>
<td>Orthostatic changes</td>
<td>Overt hypotension</td>
<td>Overt hypotension</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Anxious</td>
<td>Anxious</td>
<td>Anxious and Confused</td>
<td>Confused and Lethargic</td>
</tr>
<tr>
<td>Urine Output</td>
<td>≥ 30 mL/hr</td>
<td>20-30 mL/hr</td>
<td>5-15 mL/hr</td>
<td>Anuria</td>
</tr>
<tr>
<td>Cap Refill</td>
<td>Normal</td>
<td>&gt;2 seconds</td>
<td>&gt;2 seconds Cold &amp; clammy</td>
<td>&gt;2 seconds Cold &amp; clammy</td>
</tr>
<tr>
<td>Fluid Replacement (3:1 Rule)</td>
<td>Crystalloids</td>
<td>Crystalloids</td>
<td>Crystalloids &amp; blood</td>
<td>Crystalloids &amp; blood</td>
</tr>
<tr>
<td>Labs</td>
<td>CBC; PT/PTT; Fibrinogen; T&amp;S versus T&amp;C; FDP; Platlets; D-dimer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Replacement</td>
<td>Crystalloids → Transfuse PRBCs → Transfuse other (FFP, Cryo, Plts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Abatement</td>
<td>Massage → Uterotonics → Surgery → Packing/Tamponade/Embolization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Estimating Blood Loss (EBL): Guide to objective measurement of blood loss*

- 1 cup = 250 mL
- 5 cm clot (orange) = 1 unit of PRBCs
- 12 oz soda can = 355 mL
- 2 cups = ~500 mL
- 10 cm clot (softball) = 2 units of PRBCs
- Floor spills:
  - 20” (50 cm) = 500 mL
  - 30” (75 cm) = 1000 mL
  - 40” (100 cm) = 1500 mL
- Ideal method is weighing:
  - 1 g of blood = 1 mL
Maternal Hemorrhage: Recognition and Treatment (continued)
Placenta Abruption

Term/Near Term

Fetus alive
- Reassuring fetal status
- Stable mother
  - Transfer to hospital with OB services
  - Vaginal delivery
- Contraindications to vaginal delivery:
  - Non-reassuring fetal status
  - Unstable mother
  - Emergent delivery necessary via Cesarean delivery

Fetus dead
- Vaginal delivery
  - Failure to progress
  - Unstable mother
  - Cesarean delivery
- Contraindications to vaginal delivery

Preterm

Fetus alive <24 weeks
- Assess
  - Unstable mother
  - Emergent delivery necessary
  - Stable mother
  - Manage conservatively

Fetus alive >24 weeks
- Assess
  - Non-reassuring fetal status
  - Unstable mother
  - Emergent delivery necessary
  - Reassuring fetal status
  - Stable mother
  - Manage conservatively and transport to hospital with OB services

Fetus dead
- Deliver
  - Ensure proper documentation
  - Debrief staff
  - Provide emotional support to parents

In all cases:
- Check CBC and coagulation indices
- Replace blood volume (refer to pg. 5 for Maternal Hemorrhage)
- Correct coagulopathies
- Monitor I & O’s and renal function

Deliver between 37-38 weeks

Give steroids
- Tocolytics as indicated
- Closely monitor fetus and mother

Illinois EMSC
## Trauma

### Prenatal Trauma Management (ACEP)

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General concepts</strong></td>
<td>• Medications, tests, treatments and procedures required to stabilize the mother should not be withheld because of pregnancy.</td>
</tr>
<tr>
<td></td>
<td>• Evaluate for possible pregnancy-related causes for an accident (i.e. seizure secondary to eclampsia)</td>
</tr>
<tr>
<td></td>
<td>• Maternal physiologic changes may delay signs of shock</td>
</tr>
<tr>
<td></td>
<td>o Monitor urine output and fetal heart tracing patterns to provide early warning signs instead of only the mother’s pulse and BP</td>
</tr>
<tr>
<td></td>
<td>• Consult Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient, to individualize the care</td>
</tr>
<tr>
<td></td>
<td>of patient, if patient needs to be transferred and as needed for further support and consult.</td>
</tr>
<tr>
<td><strong>Positioning</strong></td>
<td>• Place any pregnant patient &gt;24 weeks gestation in left lateral decubitus position to avoid hypotension. Right lateral decubitus position is also acceptable.</td>
</tr>
<tr>
<td></td>
<td>• If patient is on a backboard, tilt it toward the left or place a wedge under right side</td>
</tr>
<tr>
<td></td>
<td>• If patient’s BP is unstable or concerns exist regarding cervical spine injury, patient should be log-rolled with her neck being stabilized</td>
</tr>
<tr>
<td><strong>Hypotension</strong></td>
<td>• Administer IV fluids and consider blood transfusion</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>• Criteria for definition: &gt;140 systolic and &gt;90 diastolic;</td>
</tr>
<tr>
<td></td>
<td>• Treat &gt;160 systolic and &gt;110 diastolic with labetalol 10-20mg IV bolus</td>
</tr>
<tr>
<td><strong>Fetal/Uterine Monitoring</strong></td>
<td>• Initiate fetal monitoring for viable fetus as soon as mother is stabilized (if available and trained personnel available to stay with patient)</td>
</tr>
<tr>
<td></td>
<td>• If fetal monitoring unavailable, check fetal heart tones via doppler</td>
</tr>
<tr>
<td></td>
<td>• A viable fetus should be placed on continuous monitoring until under the care of the obstetrician.</td>
</tr>
<tr>
<td></td>
<td>• Electronic fetal heart and uterine monitoring in pregnant trauma patients &gt;20 weeks gestation may detect placental abruption</td>
</tr>
<tr>
<td></td>
<td>• Continuous monitoring can be discontinued after 4 hours if there are no fetal heart rate abnormalities, uterine contractions, bleeding or uterine tenderness</td>
</tr>
<tr>
<td><strong>Vaginal Bleeding</strong></td>
<td>• Treat heavy vaginal bleeding the same as hypovolemic shock</td>
</tr>
<tr>
<td></td>
<td>• Massive continual vaginal bleeding may require emergency cesarean delivery</td>
</tr>
<tr>
<td></td>
<td>• Obtain OB consultation</td>
</tr>
<tr>
<td></td>
<td>• Administer RhiG to Rh negative patients</td>
</tr>
<tr>
<td><strong>Lab tests</strong></td>
<td>• CBC (monitor hemoglobin/platelet count)</td>
</tr>
<tr>
<td></td>
<td>• Type and Screen (monitor for Rh negative)</td>
</tr>
<tr>
<td></td>
<td>• Kleihauer-Betke</td>
</tr>
<tr>
<td></td>
<td>• Coagulation panel (INR, PTT, fibrin degradation, fibrinogen, i-COOMBS)</td>
</tr>
<tr>
<td><strong>Diagnostics</strong></td>
<td>• Diagnostic procedures to evaluate potentially serious traumatic injuries should not be withheld for fetal concerns. Order exams</td>
</tr>
</tbody>
</table>
for the same indications as non-pregnant trauma patients
  - A complete trauma exam with CT scanning will not approach radiation levels that adversely affect the fetus.
  - Consider ultrasound to replace x-ray when possible
  - Shield abdomen, pelvis and neck when possible

### Treatments: IV Fluids
- Larger fluid requirements when hypotensive
- Avoid administering large amounts of IVF containing Dextrose which can cause glucose regulation difficulties in neonates if delivery is imminent

### Treatments: Intubations and RSI
- Same as non-pregnant patients

### Treatments: Medications
| Analgesia: | Acute trauma pain control with narcotics can be given in any trimester as needed
| Antibiotics: | Ceftriaxone or clindamycin
| Antiemetics: | Metoclopramide or Zofran

### Treatments: Oxygen
- Provide high concentrated O₂

### Treatments: Rh negative patients
- RhIG 1 ampule (300g) IM

### Treatments: Seizures
- Eclamptic: magnesium sulfate 6g IV/IO load over 15-20 minutes
- Non-eclamptic: lorazepam 1-2mg/min IV/IO

### Treatments: Tetanus
- Safe in pregnancy

### Treatments: Transfusions
- CMV antibody negative; Leukocyte reduced

### CPR/ACLS
- Left lateral decubitus; no response after 4 minutes of CPR, consider cesarean for viable fetus

### Maternal Death
- Consider immediate cesarean delivery for a viable fetus in any patient who cannot be resuscitated
- Consider immediate cesarean delivery in cases of brain death in mother with intact cardiovascular system if fetal compromise is present
- Consider maintaining life support management until fetus is at an acceptable level of maturity for delivery
Prolapsed Cord

Risk factors for cord prolapse:
- PROM*
- Breech position
- Multiple gestation
- Long umbilical cord
- Spontaneous labor with high head and increased amniotic fluid
- Every vaginal exam (VE), check for and exclude presentation/ prolapsed cord

Anticipate

Suspect

Diagnose

Call for help

Establish condition

Perform speculum exam

PROM* or PPROM** with risk factors for cord prolapse
PROM or PPROM with abnormal fetal heart monitoring

Cord visible, seen with speculum or felt during VE

Notify (if available at hospital):
- Anesthesiologist
- Neonatologist
- Obstetrician
- On-call surgeon
- Contact the Pediatric Care Medical Specialist for OB and Neonatal consultation if services unavailable at hospital and to assist with transfer to NICU after delivery

Determine if fetus is alive:
- Cord pulsations
- Fetal stethoscope
- Hand held Doppler
- Ultrasound
- Fetal heart monitors

Fetus alive

Fetus dead

Confirm fetal death by ultrasound if available

Plan of action:
- Mode of delivery is what is safest for mother
- Non-urgent (as long as no maternal complication and mother is stable)
- Provide counseling to parents

*PROM=premature rupture of membranes (term fetus)
**PPROM= Preterm premature rupture of membranes

Illinois EMSC
www.luhs.org/emsc
Fetus alive

Cervix not fully dilated

Relieve compression and prevent vasospasm of cord
- Head low (Trendelenburg, knee-chest or left lateral position with pelvis elevated
- O₂ via face mask at 8L/min
- Place gloved fingers into vagina between pubic bone and presenting part with the cord in between two fingers and exert counter pressure on presenting part and maintain pressure until baby can be delivered
- Do not push cord back into vagina
- Cover exposed cord with moist dressing and keep warm

Transfer to operating room, maintaining relief of cord compression

Reconfirm fetus is alive (Ultrasound scan if possible)

Emergency cesarean section
Empty bladder before entering peritoneal cavity
Prepare for neonatal resuscitation and transfer to Level III Perinatal Center after delivery

Cervix fully dilated

Vacuum delivery
Forceps delivery
Assisted breech delivery
Breech extraction

Ensure proper documentation
Debrief staff
Provide counseling to parents about treatment options
Provide emotional support to parents
**Breech Birth**

Gravida in labor with fetus in breech position

Assess for contributing factors:
- Preterm labor
- Placenta Previa
- Fetal anomalies
- Multiple gestation
- Uterine malformation
- Leomyomata uteri

Reasons against vaginal breech delivery?
- Macrosomic
- Premature or small for dates fetus
- Macrocephaly
- Pre-term labor
- Fetal tumors
- Contracted or distorted pelvis
- Unavailable skilled, experienced practitioner

Signs of adverse details of breech presentation?
- Posterior sacral position
- Incomplete breech presentation
- Extended fetal head

Optimal candidate for breech delivery with no adverse risk factors

Determine labor status

Not in labor

Await active labor

Vaginal vertex delivery

**Monitor for head entrapment (cervix clamping around neck as body is delivered). This is an emergent situation. Contact OB experts for assistance.**

Vaginal vertex delivery

Labor in progress

Early labor with intact membranes

Await active labor

Normal cervical dilatation and fetal descent** and frank breech

Vaginal breech delivery

Protrusion or arrest pattern or 1 foot/leg is presenting part

Vaginal delivery contraindicated

Cesarean delivery

*Follow progression pattern in active phase*

**YES**

**YES**
Shoulder Dystocia

Shoulder dystocia:
Anterior shoulder of the baby becomes impacted against the symphysis pubis preventing the shoulders from descending through the pelvis.

Possible Risk Factors:
- Antenatal
  - Previous shoulder dystocia
  - Fetal macrosomia
  - Maternal diabetes
  - Maternal obesity
  - Postdate pregnancy
  - Short stature
- Intrapartum
  - Prolonged first stage
  - Prolonged second stage
  - Labor augmentation
  - Instrumental delivery
  - Precipitate birth
  - Uterine hyperstimulation
- Maternal
  - Ruptured uterus
  - Postpartum hemorrhage
  - Perineal tears
  - Emotional trauma
- Neonatal
  - Brachial plexus injury
  - Fractured clavicle
  - Birth asphyxia
  - Neonatal death

Complications:
- Ruptured uterus
- Brachial plexus injury
- Fractured clavicle
- Birth asphyxia
- Neonatal death

Identify shoulder dystocia
Turtle sign (chin retracts and depresses the perineum)
Failure of fetal head to restitute
Head when delivered may be tightly applied to vulva
Failure of shoulders to descend
Anterior shoulder fails to deliver with routine traction

Notify (if available at hospital):
- Anesthesiologist
- Neonatologist
- Obstetrician
- On-call surgeon

Contact the Pediatric Care Medical Specialist for OB and Neonatal consultation if services unavailable at hospital and to assist with transfer to NICU after delivery

Discourage pushing

McRoberts Maneuver (abduct and hyper flex legs against abdomen)

Suprapubic pressure (apply pressure in a downward, lateral direction just above the maternal symphysis pubis to push the posterior aspect of the shoulder towards fetal chest)

Consider episiotomy if it will make internal maneuvers easier

Try either maneuver first, depending on clinical circumstances and clinician experience

Deliver posterior arm

Internal rotation maneuvers:

If all above maneuvers fail to release the impacted shoulder, consider placing patient in all fours position or repeat the above

Secondary Maneuvers:
- Cleidiotomy: deliberate fracture of clavicle
- Zavanelli Maneuver: restoring fetus into uterus and performing a cesarean section (contraindicated if a nuchal cord has been previously clamped and cut)
- Symphysiotomy: contact Pediatric Care Medical Specialist

Ensure proper documentation
Debrief staff
Provide counseling to parents on treatment options
Provide emotional support to parents

Illinois EMSC
www.luhs.org/emsc
Group B Streptococcus (GBS): a gram-positive organism, known to colonize the lower GI tract, with the potential for secondary spread to the genitourinary tract and subsequent transmission to the fetus during delivery. GBS is a leading cause of serious neonatal infection with case-fatality rate reported to be as high as 20% in newborns.

Inquire about GBS status during initial assessment of all laboring patients that present to hospital. Complete a vaginal and rectal GBS screening cultures at 35 – 37 weeks’ gestation for ALL pregnant women [unless patient had GBS bacteriuria during the current pregnancy or a previous infant with invasive GBS disease]

**RECOMMENDED REGIMENS FOR INTRAPARTIAL ANTIMICROBIAL PROPHYLAXIS FOR GBS PREVENTION**

<table>
<thead>
<tr>
<th>Recommended</th>
<th>Penicillin G, 5 million units IV initial dose, then 2.5-3.0 million units every 4 hrs until delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative</td>
<td>Ampicillin 2 grams IV initial dose, then 1 gram every 4 hrs until delivery</td>
</tr>
</tbody>
</table>

**IF PENICILLIN ALLERGIC**

| Low Risk for Anaphylaxis | Cefazolin 2 grams IV initial dose, and then 1 gram every 8 hrs until delivery |
| High Risk for Anaphylaxis | GBS susceptible to clindamycin or erythromycin: Clindamycin 900 milligrams every 8 hrs until delivery |
|                         | GBS resistant to clindamycin or erythromycin or susceptibility unknown: Vancomycin** 1 gram every 12 hours until delivery |

*If onset of labor or rupture of amniotic membranes occurs at <37 weeks’ gestation and there is a significant risk for preterm delivery (as assessed by the clinician), follow the algorithm below for GBS prophylaxis management.

**INTRAPARTUM PROPHYLAXIS INDICATED**
- Previous infant with invasive GBS disease
- GBS bacteriuria during current pregnancy
- Positive GBS screening culture during current pregnancy (unless a planned cesarean delivery, in the absence of labor or amniotic membrane rupture, is performed)
- Unknown GBS status (culture not done, incomplete or results unknown) and any of the following:
  - Delivery at <37 weeks’ gestation*
  - Amniotic membrane rupture >18 hours
  - Intrapartum temperature >100.4°F/38.0°C

**INTRAPARTUM PROPHYLAXIS NOT INDICATED**
- Previous pregnancy with a positive GBS screening culture (unless a culture was also positive during the current pregnancy)
- Planned cesarean delivery performed in the absence of labor or membrane rupture (regardless of maternal GBS culture status)
- Negative vaginal and rectal GBS screening culture in late gestation during the current pregnancy, regardless of intrapartum risk factors

**No GBS Culture**
Obtain vaginal & rectal GBS culture and initiate Penicillin (PCN) IV
If no growth at 48hrs, stop PCN IV

**GBS Positive**
PCN IV for ≥ 48 hrs (during tocolysis)
Intrapartum antibiotic prophylaxis

**GBS Negative**
No GBS Prophylaxis
If undelivered in 6+ weeks repeat culture
Maternal Cardiopulmonary Arrest

If the mother suffers from cardiopulmonary arrest, follow Advance Cardiac Life Support guidelines. The following are additional guidelines for care of pregnant women in cardiopulmonary arrest:

- Displace the uterus either manually or by placing a hip roll under the patient’s right hip. Left tilt is preferable, however, either side would benefit the patient if left tilt is not possible.
- If present, remove fetal monitors before defibrillation or cardioversion. This also includes removing internal monitors.
- Do not give Amiodarone before the baby is delivered as it will cause severe hypothyroidism in an already compromised infant. Lidocaine is the antiarrhythmic of choice before delivery.
- Delivery by post mortem emergent cesarean section should be accomplished within the first 5 minutes of the maternal code.

Management of Other Common Delivery Complications

For additional common delivery complications, consult the Pediatric Care Medical Specialist for assistance and guidance with both obstetrical and pediatric care.
**INITIAL CONTACT**
- Unable to obtain information from patient: (skip to Assessment section)
- Reason for admission:
  - Gestation: __________ weeks
  - LMP: __________
  - Number of current gestation:
    - Single gestation
    - Multiple gestation (number): __________

**HISTORY**
- What number pregnancy is this? __________
- Number of:
  - Previous deliveries: __________
  - Term: _______ Pre-term: _______
  - Abortion: _______ Living children: _______
- Mode of previous deliveries:
  - Vaginal
  - Cesarean Section
- Medical history:
  - __________________________________________
- Surgical history:
  - __________________________________________
- Previous uterine surgery:
  - __________________________________________
- Home medications:
  - __________________________________________
- History of pre-natal care:
  - __________________________________________
- Known antenatal fetal defect/special conditions of the fetus:
  - __________________________________________
- Known Group B Strep (GSB) status
  - Positive □ Negative □ Unknown
- Known high risk pregnancy:
  - __________________________________________
- History of drug use:
  - __________________________________________

**ASSESSMENT/INTERVENTIONS**

**Vaginal bleeding**
- History of bleeding disorders and/or taking medications for bleeding disorders: __________
- Time of onset of bleeding: __________
- Description of blood loss:
  - Watery □ Bright red □ Dark red
- Estimation of blood loss:
  - Amount: __________
  - Clots: □ Number __________ □ Size: __________
  - Pain: □ Absent □ Present □ Constant □ Intermittent

**Abdomen**
- □ Rigid □ Soft □ Relaxation between contractions □ Scars
- from previous surgeries □ Fundal height __________ cm
  (uppermost border of the symphysis pubis to the upper border of the fundus)

**Contraction**
- Onset: __________ Frequency: __________
- Pain rating (0-10): __________
- Intensity: □ Mild (abdomen feels like a nose) □ Moderate (abdomen feels like a chin) □ Firm (abdomen feels like the forehead)

**Membrane status**
- □ Intact □ Ruptured: Time: __________

**Fluid**
- □ Clear □ bloody □ Meconium

**Fetal movement**
- □ Normal □ Decreased □ Absent

**Fetal Heart Tones (Rate):** __________

**Vital signs**
- HR: __________
- RR: __________
- Temp: __________
- SpO2: __________
- BP: __________

**If elevated BP:**
- History of HTN: □ Yes □ No □ Pregnancy induced
- Swelling: □ Feet and Legs □ Face □ None
- Complaints of:
  - □ Headache □ Nausea
  - □ Blurred vision and/or visual disturbances □ Epigastric pain

**Prolapsed cord present?**
- □ Yes □ No
- Are pulsations palpable: □ Yes □ No
- Doppler for Heart Rate: __________

**DISPOSITION**
- Form completed by: __________
- Date: __________
- Patient disposition:
  - □ Discharge □ Admit
  - □ Transfer: __________
- For patient’s requiring transfer:
  - Patient Triage Category:
    - □ Level III Perinatal Center Criteria
    - □ Level II-E Perinatal Center Criteria
    - □ Level I or II Perinatal Center Criteria

**ASSESSMENT/INTERVENTIONS (continued)**

**Active Labor:**
- Bloody show: □ Yes □ No
- Feeling rectal pressure, grunting or bearing down: □ Yes □ No
- Separation of labia or bulging of perineum: □ Yes □ No
- Presenting part: __________
- Scalp visible: □ Yes □ No
- Crowning: □ Yes □ No
- Time of delivery: __________

**After delivery: Mother**
- Placenta delivered: □ Yes □ No
- Time of delivery: __________
- Placenta intact: □ Yes □ No
- Uterine status: □ Firm □ Soft □ Midline
- Medications received during labor/after delivery:
  - □ Oxytocin (Pitocin)
  - □ Misoprostol (Cytotec)
  - □ Methylergometrine (Methergine)
  - □ Hemabate (Carboprost)
  - □ Magnesium
  - □ Other __________
- Bleeding description:
  - □ Dark red □ Bright red
- Bleeding amount:
  - □ Steady trickle □ Gush □ Clots

**After delivery: Baby**
- See Newborn Care Guideline for information

---

Illinois EMSC
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

---

### Initial Management of All Pediatric Patients with Influenza Like Illness (ILI)

- Stabilize ABCs (Airway, Breathing, and Circulation)
- Obtain weight (actual or use of weight/length based tool)
- Monitor
  - Heart Rate (HR), Blood pressure (BP), Oxygen Saturation (SpO₂), mental status, temperature, perfusion, urine output, bedside glucose
- Perform history & physical exam
- Provide oxygen if patient is hypoxic or in acute distress (goal is SpO₂ >95%).
  - O₂ blow-by or NC if in mild distress
  - O₂ 15L NRB or partial rebreather for moderate to severe distress
  - O₂ 15L BVM for severe distress/arrest
- Consult Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be transferred and as needed for further support and consult.

---

### Management for All Pediatric Patients with ILI

---

### TREATMENT

See [Pediatric Respiratory Care Guideline](#) for airway/respiratory management of children

**Strategic National Stockpile (SNS):**

During a Class 2 or Class 1 Health and Medical Emergency Event (multiple regions or entire state is affected by Pandemic and state disaster declaration has been issued), IDPH may deploy federally supplied medication, medical supplies and medical equipment from the CDC SNS to assist hospitals with the care and treatment of ILI of all patients, including children and newborns. Request for such resources should occur through the Request for Medical Resources process indicated in the Illinois Health and Medical Care Response Plan (ESF-8).

**Immunization:**

Annual vaccination is the most important method to prevent seasonal influenza infection. All people > 6 months old should receive the vaccination. Children, their caregivers and other members of their household should be screened for the need to receive the vaccination during a pandemic.

**Antivirals:**

Each pandemic may differ in the recommended medication for treatment and prophylaxis. Consult the Local Health Department, Pediatric Care Medical Specialist and/or the Centers for Disease Control and Prevention (CDC) for medication and pediatric dosing recommendations.

**Hydration:**

Ensure children maintain adequate hydration when experiencing ILI.

Monitor urine output:

- Normal urine output: at least 1mL/kg/hr

**IV/IO Fluids: replacement**

- Birth -28 days:
  - Bolus 0.9%NS at 10mL/kg
- 28 days:
  - Bolus 0.9% NS at 20mL/kg
**Infectious Control Measures**

**Droplet isolation**
- Maintained on hospital patients with suspected or confirmed influenza for 7 days after the onset of symptoms or for 24 hours after resolution of fever and respiratory symptoms, whichever is longer
  - Children may have prolonged viral shedding and may need isolation longer

**Facemasks and Children:**
- Helps provide a physical barrier and blocks large particle droplets when coughing/sneezing
- Should be used on children with:
  1. ILI symptoms
  2. Immuno-suppression or chronic illnesses
  3. ILI symptoms who have to leave hospital/exam room
  4. Asymptomatic children in crowded health care settings (i.e. ED waiting room)
- Considerations:
  1. Masks should not be placed on infants or any pediatric patient who is anxious, restless, vomiting, lethargic or in respiratory distress
  2. Use pediatric sized/child friendly masks if available. Adult sized masks can be folded in half to fit children’s smaller faces.

See EMSC’s *Children and Facemask... To Mask or Not to Mask..... for more information.*

**Triaging upon entry to hospital**

All patients and visitors should be screened upon entry to building for ILI and the need for PPE

Promptly separate out unexposed and exposed asymptomatic children from symptomatic children and adults (see cohorting)

For the wellbeing of the child (asymptomatic or symptomatic), it is best to keep caregiver (asymptomatic or symptomatic) with child

Provide facemasks to all who have signs/symptoms of respiratory infection/ILI

**Visitor restrictions**

Primary caregivers should not be restricted to visit their child regardless if they are potentially infectious.

Mask and other appropriate barrier methods should be implemented.

**Testing**

Surveillance and testing: frequency of reporting and testing will be determined by state and federal recommendations and reflect the pandemic severity index level
- Need to have in place ways to monitor community acquired and health care-associated transmissions

**Special considerations**

Psychosocial needs of Children: experience from isolation/disease containment may be traumatic for children and families and have similar effects as natural disasters. It is important to implement strategies during a pandemic to help build the resiliency of children and parents.

**Resource Allocation**

For information on resource allocation, see: EMSC’s *Resource Allocation Strategies for the Pediatric Population*
Cohorting

Consider cohorting children by age group as well as the groups listed below. If separating those who are suspected/exposed/symptomatic from those who are non-ILI/exposed and asymptomatic into separate areas is not possible, cohorting in same area can be accomplished by maintaining a distance of 6 feet between these two groups.

Consider the following opportunities to separate/cohort groups:

1. Upon entry to hospital (ED)
   a. ILI Assessment/Triage Area and waiting room
   b. Non-ILI Assessment/Triage Area and waiting room

2. In ED
   a. Suspected/Exposed and Symptomatic Treatment Areas
   b. Non ILI/Exposed and Asymptomatic Treatment Areas

3. Inpatient units/rooms
   a. Confirmed Influenza
   b. Suspected/Exposed to ILI (may be merged with Confirmed Influenza as pandemic progresses and resources are limited)
   c. Not exposed/Immune and Asymptomatic

Perinatal and Newborn Considerations:

1. Whenever possible, keep health mothers and newborns together. Consider alternate sites of care for mothers and newborns who are Not exposed/Asymptomatic.

2. Hospitalized pregnant labor with either suspected or confirmed influenza should be placed on droplet precautions and adhere to respiratory hygiene, cough etiquette, hand hygiene and PPE

3. During delivery, droplet precautions should be maintained

4. After delivery:
   a. CDC recommends hospitals consider temporarily separating newborns from the mother in cases of suspected or confirmed influenza during hospital stay
      i. Length of separation has not been established but recommendations based on H1N1 virus:
         1. Mother received antivirals for > 48 hours
         2. Mother afebrile without antipyretics for > 48 hours
         3. Mother able to control her cough and respiratory secretions
   b. If separation not possible/accepted, allow newborn to room –in with mother but create physical barriers (i.e. curtains between mother and newborn), keeping newborn > 6 feet away from ill mother and ensure a health adult is present to care for newborn. If/when mother has direct contact with newborn, mother should wear a facemask and practice hand hygiene.
   c. Newborns of mothers with suspected or confirmed influenza can be cared for in the newborn nursery as long as no symptoms are present and should be cared for by non-ill staff. If the newborn develops symptoms, they should be placed on droplet precautions

5. Discharge home:
   a. Encourage immediate family who will have contact with newborn to receive influenza vaccination
   b. Encourage a vaccinated, non-ill family member to provide care to newborn at home until mother’s symptoms resolve
### General Influenza Concepts for All Patients

**Infectivity of the Influenza Virus:**
- **Incubation period**: 1-3 days
- **Period of Communicability**: Infectious 1 day before onset of symptoms and may be longer than 7 days after onset of symptoms

Influenza virus is inactivated by hospital germicides, household cleaning products, soap, hand wash or hand hygiene products.

It is critical that infection prevention and control policies/procedures are maintained to decrease the transmission of influenza in the hospital setting.
- **Hand Hygiene for staff, patients and visitors**
- **Hygiene measures to minimize influenza transmission**
- **PPE** (mask use, gloves)
- **Cleaning, disinfecting and sterilizing patient care equipment**
- **Environmental control** (i.e. housekeeping)

**Pandemic Severity Index**: CDC uses fatality ratio as the critical driver for forecasting a pandemic’s severity. This can help forecast the impact of a pandemic and enable recommendations to be made for mitigation strategies.
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.
Disclaimer: This guideline is not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Initial Management of a Premature Neonate

Initial management immediately following delivery should adhere to Neonatal Resuscitation Program (NRP) guidelines. This care guideline reviews the additional special care considerations for premature newborns.

Please see the Newborn Care Guideline for standard care of all newborns.

Contact the Pediatric Care Medical Specialist for guidelines on withholding and discontinuing resuscitation of a premature newborn.

General Concepts for Caring for a Premature Neonate

Premature neonates are at a much higher risk of developing complications than the term infant. The anatomy/physiology of a premature neonate increases their vulnerability to morbidity/mortality factors. Constant monitoring is necessary to determine when increased management and support are needed. Therefore, it is recommended that premature neonates be stabilized and then transferred to a center that is capable of providing neonatal intensive care as soon as safely possible given the circumstances of the disaster incident.
# Management of a Premature Neonate

## AIRWAY

**Preterm Neonates that require oxygen:**
- Neonates with spontaneous respirations may be given supplemental oxygen per:
  - Neonatal nasal cannula at 1-2 LPM flow
  - Oxygen mask
  - Flow-inflating bag and mask
  - Oxygen hood or blow-by O₂ with O₂ tubing held close to neonate’s face
  - CPAP (if available) with a PEEP of 4 or 5

Consult Pediatric Care Medical Specialist for assistance with care if respiratory support needs go beyond the above methods.

**Preterm neonates that require assisted ventilation:**
- Follow Neonatal Resuscitation Program (NRP) guidelines for initiating positive pressure ventilation (PPV):
  - Heart rate < 100 bpm
  - Gasping respirations
  - Apnea
- Use the appropriate sized bag for PPV—maximum volume of 750 mL, and appropriate sized neonatal mask
- Monitor inflation pressures carefully.
  - Initial inspiratory pressure of 15-20 cm H₂O
  - Deliver subsequent breaths with approximately 15 cm H₂O of pressure, or just enough pressure to see the chest rise
- Best indication that PPV is effective is:
  - Increasing heart rate
  - Auscultation of equal breath sounds bilaterally
  - Color improvement
  - Increased oxygen saturation per pulse oximetry

**Avoid hypoxia/hyperoxia**
- All neonates receiving O₂ should have oxygen saturations closely monitored with pulse oximetry
- Neonates ≤ 1250 grams at birth maintain SpO₂ between 85-92% with supplemental oxygen
- Use an oxygen blender in the delivery of supplemental O₂ so that the FiO₂ may be titrated according to pulse oximetry

**Preterm neonates that require prolonged assisted ventilation:**
- Consider intubation. See endotracheal intubation below for more information.
- The potential risk for serious complications with intubation and ventilator management is high. It is recommended to consult the Pediatric Care Medical Specialist for assistance with care.

**Consider surfactant therapy for preterm neonates who have clinical signs of respiratory distress syndrome:**
- Signs of impairment in oxygenation:
  - PaO₂ < 50 mmHg in room air, central cyanosis in room air
  - O₂ required to maintain PaO₂ > 50mmHg, or required supplemental oxygen to maintain pulse oximeter saturation over 85% in the first 24 hours of life
  - Newborn is often tachypneic with grunting, nasal flaring and chest retractions. Lung sounds may be decreased with rales present.
- **AND,** chest radiograph is consistent with Respiratory Distress Syndrome (reticulogranular appearance of lung fields with or without low lung volumes and air bronchograms within the first 24 hours of life)
- Should only be considered and administered by care providers with expertise in surfactant administration. The potential for complications with surfactant administration is high. Consult Pediatric Care Medical Specialist for assistance with care.
**Endotracheal Intubation**

Endotracheal tube size is determined based on the neonate’s weight or gestation.

<table>
<thead>
<tr>
<th>Weight (in grams)</th>
<th>Gestational Age (in weeks)</th>
<th>Endotracheal Tube Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1000 grams</td>
<td>&lt;28 weeks gestation</td>
<td>2.5 uncuffed*</td>
</tr>
<tr>
<td>1000-2000 grams</td>
<td>28-34 weeks gestation</td>
<td>3.0 uncuffed*</td>
</tr>
<tr>
<td>2000-3000 grams</td>
<td>34-38 weeks gestation</td>
<td>3.5 uncuffed*</td>
</tr>
</tbody>
</table>

*Cuffed endotracheal tubes are not recommended for the neonatal population.*

Determine the initial depth of endotracheal tube insertion using the 'Tip-to-lip' rule:

Add 6 to the neonate’s weight in kg to determine the centimeter marking on the Endotracheal tube at the lip.

For example a neonate that weighs 2,030 grams: $6 + 2 = 8$ cm marking at the lip.

Correct Endotracheal tube placement is confirmed with chest x-ray, and should be at the level of T1- T3 (Below the clavicles and above the carina).

---

**THERMOREGULATION**

Premature neonates are at an increased risk of developing hypothermia and are more vulnerable to cold stress than the term neonate. The axillary temperature should be monitored within the first 30 minutes of life, and then every 1 hour, and should be maintained between 97.7° F and 99.5° F (36.5° C and 37.5° C). Continue to monitor temperature every 1-3 hours once stabilized.

Measures that may prevent hypothermia include:

1. Increase the room/delivery room temperature $>25°$ C (77° F)
2. Use of radiant warmer for resuscitation if available
3. Use of chemical warming mattress
   - **A. Caution:** Place receiving blanket on chemical warming mattress to avoid direct skin contact with warming device
4. Use of occlusive/polyethylene wrap or large plastic bag (i.e. gallon size food grade storage bag) for neonates $<28-30$ weeks gestation.
   - **A.** Wrap neonate in occlusive wrap up to the neck, or insert entire body of neonate up to the neck in plastic bag
   - **B. Caution:** Do not allow plastic to cover any part of the face
5. Use of knit hat
6. Neonates $>32$ weeks gestation may be placed skin-to-skin with mother if stable. Place unwrapped, undressed neonate directly onto mother’s chest/abdomen and cover both with warm blankets.
7. **To avoid burns, Never use hot water bottles or gloves filled with hot water to warm the neonate.**
HYPOGLYCEMIA

There is no consensus as to what specific plasma glucose concentration defines a normal glucose value. Because premature neonates are at an increased risk of hypoglycemia, it is recommended that the blood glucose levels be maintained between >50 and <200mg/dL. Monitor blood glucose within the first hour of birth, and then every 1-3 hours if stable.

<table>
<thead>
<tr>
<th>IV FLUIDS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish IV access</td>
<td></td>
</tr>
<tr>
<td>Preferred IV fluids for infusion during first 24 hours of life is D10W</td>
<td></td>
</tr>
<tr>
<td>After 24 hours, consider need to add electrolytes</td>
<td></td>
</tr>
<tr>
<td>Initial maintenance rate: 80 mL/kg/day</td>
<td></td>
</tr>
<tr>
<td>Calculation example: 1.8kg X 80mL divided by 24 = rate of 6 mL per hour</td>
<td></td>
</tr>
<tr>
<td>Always administer IV fluids via infusion pump</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GLUCOSE BOLUS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For blood glucose &lt; 50 mg/dL, administer a glucose bolus:</td>
<td></td>
</tr>
<tr>
<td>D10W, 2 mL/kg at a rate of 1mL/min</td>
<td></td>
</tr>
<tr>
<td>Calculation example: 1.8kg X 2 = 3.6mL to be administered over 4 minutes</td>
<td></td>
</tr>
<tr>
<td>Recheck blood glucose (use heel for site) within 15 min. post bolus infusion</td>
<td></td>
</tr>
<tr>
<td>Repeat glucose bolus if blood glucose remains &lt; 50 mg/dL</td>
<td></td>
</tr>
<tr>
<td>Premature neonates with persistent low blood glucose may need to consider increasing IV glucose maintenance fluid rate or IV fluid glucose concentration. Consult Pediatric Care Medical Specialist for assistance with care</td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL SPECIAL CONSIDERATIONS FOR PREMATURE NEONATES

<table>
<thead>
<tr>
<th>METHODS TO DECREASE RISK OF INTRAVENTRICULAR HEMORRHAGE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Handle the neonate gently</td>
<td></td>
</tr>
<tr>
<td>Closely monitor pressures delivered if positive-pressure ventilation is needed</td>
<td></td>
</tr>
<tr>
<td>Avoid big changes in pulmonary pressures</td>
<td></td>
</tr>
<tr>
<td>Avoid delivering high pressures if possible</td>
<td></td>
</tr>
<tr>
<td>Avoid rapid infusion of IV boluses and fluids</td>
<td></td>
</tr>
<tr>
<td>Avoid hypertonic solutions</td>
<td></td>
</tr>
<tr>
<td>Make any changes in care/management, (i.e. ventilation or O2 requirements), gradually and according to assessment of response</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESSING THE INCREASED RISK OF INFECTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain blood lab work to include blood cultures and CBC</td>
<td></td>
</tr>
<tr>
<td>IF UNABLE TO OBTAIN BLOOD WORK OR LUMBAR PUNCTURE, AND NEONATE AT RISK FOR INFECTION, ADMINISTER ANTIBIOTICS AS SOON AS POSSIBLE</td>
<td></td>
</tr>
<tr>
<td>Initiate antibiotic therapy promptly:</td>
<td></td>
</tr>
<tr>
<td>Ampicillin: 100mg/kg IV every 12 hours. Infuse over 30 min.</td>
<td></td>
</tr>
<tr>
<td>Gentamycin: Consult Pediatric Care Medical Specialist for assistance with dosing.</td>
<td></td>
</tr>
</tbody>
</table>
### Other Premature Neonate Considerations

#### RISK FACTORS

<table>
<thead>
<tr>
<th>MATERNAL RISK FACTORS</th>
<th>NEONATAL RISK FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Chronic Hypertension</td>
<td>● Prematurity (&lt;37 weeks)</td>
</tr>
<tr>
<td>● Pregnancy-induced hypertension</td>
<td>● Small for gestational age (&lt;10th percentile for gestational age)</td>
</tr>
<tr>
<td>● Illicit and certain prescription drugs use</td>
<td>● Large for gestational age (&gt;90th percentile for gestational age)</td>
</tr>
<tr>
<td>● Tobacco, alcohol use</td>
<td>● Intrauterine growth retardation (IUGR)</td>
</tr>
<tr>
<td>● Diabetes Mellitus</td>
<td>● Infection</td>
</tr>
<tr>
<td>● Premature or prolonged rupture of membranes</td>
<td>● Birth trauma</td>
</tr>
<tr>
<td>● Maternal infection</td>
<td>● Meconium stained amniotic fluid</td>
</tr>
<tr>
<td>● Oligohydramnios/Polyhydramnios</td>
<td></td>
</tr>
</tbody>
</table>

#### UNIQUE ANATOMY/PHYSIOLOGY CONSIDERATIONS RELATED TO MEDICAL MANAGEMENT OF THE PREMATURE NEONATE

<table>
<thead>
<tr>
<th>MANAGEMENT</th>
<th>ANATOMICAL/PHYSIOLOGICAL CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>● Weak chest muscle anatomy → may cause ineffective breathing</td>
</tr>
<tr>
<td></td>
<td>● Immature nervous system → decreased or absent respiratory drive</td>
</tr>
<tr>
<td></td>
<td>● Deficient surfactant production</td>
</tr>
<tr>
<td></td>
<td>● Vulnerable to hyperoxia</td>
</tr>
<tr>
<td></td>
<td>● Lung anatomy more fragile and less compliant than term neonates</td>
</tr>
<tr>
<td>Thermoregulation</td>
<td>● High risk of rapid heat loss → hypothermia</td>
</tr>
<tr>
<td></td>
<td>● Thin skin</td>
</tr>
<tr>
<td></td>
<td>● Large surface area to body mass ratio</td>
</tr>
<tr>
<td></td>
<td>● Decreased or no fat stores</td>
</tr>
<tr>
<td></td>
<td>● Risk of ↑ evaporative water loss → promoting heat loss</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>● Diminished glycogen stores: most hepatic glycogen stores are gained in the third trimester of pregnancy</td>
</tr>
<tr>
<td></td>
<td>● Decreased fat stores</td>
</tr>
<tr>
<td></td>
<td>● Potential increased glucose utilization due to respiratory distress, hypoxia, hypothermia</td>
</tr>
<tr>
<td>Intraventricular hemorrhage</td>
<td>● Fragile germinal matrix → increased risk in preemies &lt;32 weeks gestation</td>
</tr>
<tr>
<td>Increased risk of infection</td>
<td>● Immature immune system</td>
</tr>
<tr>
<td></td>
<td>● Association of preterm labor with maternal infection (i.e. chorioamnionitis)</td>
</tr>
<tr>
<td></td>
<td>● Preterm premature rupture of membranes, and/or rupture of membranes &gt; 18 hours</td>
</tr>
</tbody>
</table>
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Initial Management of All Pediatric Patients Involved in Radiological Event

- Determine if decontamination is needed due to external contamination (See below and pages 4 & 5 for information specific to decon)
- Stabilize ABCs (Airway, Breathing, Circulation)
- Immobilize spine as indicated
- Perform history and physical exam
- Look for other injuries (trauma)
- Keep patient NPO (including pacifiers)
- Follow your own hospital radiological response policy, if applicable.
- Consult Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be transferred and as needed for further support and consult.
- Contact the IEMA Communication Center (1-217-782-7860 OR 1-800-782-7860) to report that any type of radiologic event has occurred and/or report that patients arriving at the hospital have been involved in any type of radiologic incident.
- It is recommended that hospitals consult REAC/TS (Radiation Emergency Assistance Center/Training Site) for questions regarding additional care management information (24 hour emergency phone number: 865-576-1005)

Steps for Decontaminating Externally Contaminated Pediatric Patients

- Admit to controlled area
- Remove clothing (cut clothing in direction away from patient’s airway and roll it outward away from patient’s skin, trapping any material inside the clothes)
- Place all clothing in plastic bags for testing
- Assess for and stabilize any emergent medical issues
- Obtain medical/event history if patient or family able to provide
- Identify/contain contaminate
- Minimize any additional possible intake
- Follow IEMA, REAC/TS, and/or Department of Nuclear Safety recommendations
- See next page for general Information about Radiological Decontamination

Decontamination Order Priority:
1. Wounds
2. Body Orifices
3. Intact skin

Reassess all areas after decon

Contamination reduced to acceptable levels?

YES

BEGIN medical treatment (see page 2)

NO
Management for All Pediatric Patients Involved Radiological Event

Does patient have possible external irradiation or internally contaminated (see page 4 for definitions)?
- If externally contaminated and patient is medically stable, follow decontamination procedures as indicated on previous page before beginning these recommended care guidelines.
- If externally contaminated and patient is medically unstable, stabilize prior to decon.
- Consult REAC/TS and Pediatric Care Medical Specialist for lab exams based on exposure and resources.
- Minimize uptake or facilitate excretion of contaminant through use of recommended medications and other techniques. (See next page for further management).
- Perform wound closures and any other surgical interventions within first 48 hours of irradiation (before wound healing and immunity is impaired).
- Follow normal treatment procedures.
- Observe for vomiting for 24 hours.
- If no vomiting, discharge home with medical and radiological specialist follow up.
- Admit patient. Consult with REAC/TS and Pediatric Care Medical Specialist to assist with determining need for admission, transfer or discharge.
- Repeat CBC with differential every 4-6 hours for as long as REAC/TS recommends.
- Administer antiemetics
  - Ondansetron (Zofran):
    - >6 months-4 years = 0.15mg/kg IV/SQ/IO q4 hours
    - 4-11 years = 4mg SQ/PO q4 hours
    - >12 years = 8mg SQ/PO q12 hours
  - Granisetron (Kytril):
    - > 2 years = 10mcg/kg IV/IO over 5 minutes once a day OR 2mg PO once a day
- Reassess
  - Significant absolute lymphocyte decrease or other medical problems?
    - NO
      - Discharge home with appropriate medical and radiological specialist follow up.
    - YES
      - Continuous care:
        - Medical evaluation and treatment (see next page)
        - Continue to collect excretions as per REAC/TS recommendations
        - Perform a dose assessment
        - Consult REAC/TS and Pediatric Care Medical Specialist for lab exams based on exposure and resources for ongoing laboratory testing
      - Cytogenetics
        - Biodosimetry (gold standard for determining whole-body radiation dose. Contact REAC/TS for more information).
Medical Management (Continued)

Medical management is dependent upon the type of specific isotope and the amount of exposure so identifying agent as quickly as possible is important.

Several categories of medical management for internal contamination:

1. Reduction and/or inhibition of absorption of isotope in the GI tract
2. Blocking uptake to the organ of interest
3. Isotope dilution
4. Altering the chemistry of the substance
5. Displacing the isotope from receptors
6. Traditional chelation techniques
7. Early excision of radionuclides from wounds to minimize absorption
8. Bronchoalveolar lavage for severe cases of insoluble inhaled particles

Extensive information for medical management of patients with radiation exposure can be obtain by contacting REAC/TS or in The Medical Aspects of Radiation Incidents, which can be found on REAC/TS website at www.orise.orau.gov/reacts

Safety and effectiveness of many of the therapy recommendations have not been established in the pediatric patient. Contact Pediatric Care Medical Specialist and/or REAC/TS representative for treatment recommendations.

The following medications (potassium iodide and Prussian blue) can be obtain through the Strategic National Stockpile (SNS). Hospitals should follow their existing policy to request medications from the SNS. For questions or concerns regarding the policy to request medication from the SNS, hospitals can contact their local health departments, Regional Hospital Coordinating Center (RHCC) or the Pediatric Care Medical Specialist.

Potassium Iodide (KI)

Children are susceptible to thyroid cancer after being exposed to radioactive iodine. The uptake of radioactive iodine needs to be blocked by administering oral potassium iodide (KI) within 4 hours of exposure for exposures of ≥ 0.05 Gy (5 rad). See the dosing chart below.

<table>
<thead>
<tr>
<th>Age of Patient</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 month</td>
<td>16mg PO</td>
</tr>
<tr>
<td>1 month-3 years</td>
<td>32 mg PO</td>
</tr>
<tr>
<td>4-18 years</td>
<td>65 mg PO</td>
</tr>
<tr>
<td>Pregnant or lactating women</td>
<td>130 mg PO</td>
</tr>
</tbody>
</table>

Protective effects of KI lasts approximately 24 hours and is usually given once. If child is unable to be evacuated to a safer area within 24 hours, contact Pediatric Care Medical Specialist for the possible need for repeat doses.

If liquid form is not available, below are the steps for how to convert the KI tabs to KI solution:

1. Place one 130mg tablet (or two 65mg tablets) into a bowl and grind into a fine powder.
2. Add 20ml of water to bowl and dissolve the KI powder.
3. Add 20ml of milk, juice, soda or syrup to flavor the KI/water mixture
4. Resulting solution has a concentration of 16.26mg/5ml
5. Unused iodine mixture may be stored in the refrigerator for up to 7 days.

Other considerations:

- Need to monitor a newborn’s thyroid function 2-3 weeks after receiving KI because KI can cause a transient decrease in thyroxin and increase in the TSH level
- Breastfeeding:
  - The Food and Drug Administration (FDA) and American Academy of Pediatrics (AAP) have each released recommendations for breastfeeding after a mother has been exposed to radiation. The FDA’s recommendation is a mother can breast feed after she has been treated with KI. The AAP recommends that mothers do not breast feed, even if they have been treated with KI unless no other alternative is available. For more information or assistance with determining if breast feeding should continue, consult the Pediatric Care Medical Specialist and/or REAC/TS.
**Prussian Blue**

Prussian Blue is utilized when the source is cesium, rubidium or thallium. The dosing recommendations are:

- Children 2-12 years old: 1 gm PO TID
- Children >13 years old: 3 gm PO TID

---

### Approximate Thresholds for Acute Radiation Syndromes

<table>
<thead>
<tr>
<th>Dose</th>
<th>Syndrome</th>
<th>Signs/Symptoms*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100 rads (0-1 Gy)</td>
<td>NA</td>
<td>Generally asymptomatic, potential slight drop in lymphocytes later (near 1 Gy)</td>
</tr>
<tr>
<td>&gt; 100 rads (&gt; 1 Gy)</td>
<td>Hematopoietic</td>
<td>Anorexia, nausea, vomiting, initial granulocytosis and lymphocytopenia.</td>
</tr>
<tr>
<td>&gt; 6-800 rads (&gt; 6-8 Gy)</td>
<td>Gastrointestinal</td>
<td>Early severe nausea, vomiting, watery diarrhea, pancytopenia</td>
</tr>
<tr>
<td>&gt; 2000 rads (&gt; 20 Gy)</td>
<td>Cardiovascular/ CNS</td>
<td>Nausea/vomiting within first hour, prostration, ataxia, confusion</td>
</tr>
</tbody>
</table>

* At higher doses the time to onset of signs/symptoms may be compressed.

---

### Psychological Considerations

Radiation emergencies, whether it be from a leak at a nuclear power plant or from a terrorist type incident such as a dirty bomb, leads to significant public anxiety. The anxiety associated with such events can appear out of proportion to the radiation induced health effects and can greatly affect the entire community. Many patients may present with symptoms such as nausea. It is important for providers to determine if nausea is from contamination or from the anxiety of the event. Long term psychological effects can manifest years after an event. General examples of long term effects include: feelings of vulnerability, PTSD, chronic anxiety, feelings of loss of control, fear of safety and health of themselves as well as future generations, and multiple idiopathic physical symptoms (MIPS). Provide educational materials and counseling options to all patients and their families after a radiological emergency.

---

### Radioactive Contamination versus Exposure

- **Radioactive contamination**: radioactive material is on or inside a person
  - External contamination-radioactive material is only on outside of a person
  - Internal contamination-radioactive material is ingested, inhaled, or absorbed through the skin or open wound
- **Radiation exposure**: a person is exposed to radioactive materials
- **Difference between contamination and exposure**: Person exposed to radiation may not be contaminated. An radiation exposure means radioactive material penetrated the person’s body. For a person to be contaminated with radioactive materials, the materials must be on or inside of the person’s body.
**General Information about Radiological Decontamination**

- Typically is not emergently needed as compared to chemical decon
  - *Can begin treatment for life threatening conditions before initiating decon*
  - Low risk to health care providers if decon is delayed
- Radioactive material cannot be neutralized, only moved from one point to another
- Clean dry sheet or drapes should be applied to the area to prevent spread of contamination to uncontaminated areas
- Standard pediatric considerations for decontamination apply:
  - Use warm water (98°-110°F)
  - Do not carry infants/young children through decon shower
  - Have rewarming measures available after decon is completed
- Clean wound via baby wipes or via irrigation
  - Options: baby wipes, irrigation, OR soft cloth with soap and tepid water
- Irrigation:
  - Irrigate wound/orifice/area with sterile saline or equivalent
  - Prevent splashing
- Run-off should be directed into a receptacle (i.e. lined garbage can)
  - Keep all waste (run-off, absorbent pads, sheets, towels) for later collection and disposal
- Repeat until no further contamination is noted.
- Minor debridement may be needed if wound has foreign bodies in it
- After decon completed, clean wound as per hospital protocol.
- Other considerations:
  - Partial thickness burns:
    - Always irrigate
    - Leave blisters closed
    - Irrigate open blisters
  - Full thickness burns:
    - Radioactive contaminate will slough in eschar
    - Contaminates will remain in layers of dead tissue

---

<table>
<thead>
<tr>
<th>General Information about Radiological Decontamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Typically is not emergently needed as compared to chemical decon</td>
</tr>
<tr>
<td>- <em>Can begin treatment for life threatening conditions before initiating decon</em></td>
</tr>
<tr>
<td>- Low risk to health care providers if decon is delayed</td>
</tr>
<tr>
<td>• Radioactive material cannot be neutralized, only moved from one point to another</td>
</tr>
<tr>
<td>• Clean dry sheet or drapes should be applied to the area to prevent spread of contamination to uncontaminated areas</td>
</tr>
<tr>
<td>• Standard pediatric considerations for decontamination apply:</td>
</tr>
<tr>
<td>- Use warm water (98°-110°F)</td>
</tr>
<tr>
<td>- Do not carry infants/young children through decon shower</td>
</tr>
<tr>
<td>- Have rewarming measures available after decon is completed</td>
</tr>
<tr>
<td>• Clean wound via baby wipes or via irrigation</td>
</tr>
<tr>
<td>- Options: baby wipes, irrigation, OR soft cloth with soap and tepid water</td>
</tr>
<tr>
<td>• Irrigation:</td>
</tr>
<tr>
<td>- Irrigate wound/orifice/area with sterile saline or equivalent</td>
</tr>
<tr>
<td>- Prevent splashing</td>
</tr>
<tr>
<td>• Run-off should be directed into a receptacle (i.e. lined garbage can)</td>
</tr>
<tr>
<td>- Keep all waste (run-off, absorbent pads, sheets, towels) for later collection and disposal</td>
</tr>
<tr>
<td>• Repeat until no further contamination is noted.</td>
</tr>
<tr>
<td>• Minor debridement may be needed if wound has foreign bodies in it</td>
</tr>
<tr>
<td>• After decon completed, clean wound as per hospital protocol.</td>
</tr>
<tr>
<td>• Other considerations:</td>
</tr>
<tr>
<td>- Partial thickness burns:</td>
</tr>
<tr>
<td>- Always irrigate</td>
</tr>
<tr>
<td>- Leave blisters closed</td>
</tr>
<tr>
<td>- Irrigate open blisters</td>
</tr>
<tr>
<td>- Full thickness burns:</td>
</tr>
<tr>
<td>- Radioactive contaminate will slough in eschar</td>
</tr>
<tr>
<td>- Contaminates will remain in layers of dead tissue</td>
</tr>
</tbody>
</table>
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.

Disclaimer: This guideline are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Initial Management of All Pediatric Respiratory Patients

- Stabilize ABCs and c-spine (Airway, Breathing, and Circulation)
- If exam consistent with tension pneumothorax, consider emergent needle decompression then placement of chest tube (if experienced/skilled practitioner available)
- Obtain weight (actual or use of weight/length based tool)
- Monitor:
  - Heart Rate (HR), Blood pressure (BP), Oxygen Saturation (SpO2), mental status, temperature, perfusion, urine output, bedside glucose
- Perform history & physical exam
- Provide oxygen if patient is hypoxic or in acute distress
- O2 blow by if in mild distress
- O2 15L NRB or partial rebreather for moderate to severe distress
- O2 3L BVM for severe distress/arest
- Consult pediatric expert for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be transferred and as needed for further support and consult.

Management for Respiratory Distress for All Pediatric Patients

Determine if patient is critically ill

YES

- Cyanosis
- Marked stridor
- Retractions, nasal flaring
- Inability to speak
- S/S worsening resp. distress
- Severe distress
- Unconscious
- Wheezing

NO

- Maintain position of comfort
- Provide supplemental O2 to maintain SpO2 >94%
- If wheezing, administer albuterol HHN or mask (repeat x 2)
  - 2.5mg/3mL (max single dose 5mg) AND Atrovent (ipratropium) (max repeat x 2)
  - 0.5mg/2.5mL
- Establish vascular access
- Place on cardiac and pulse ox monitor
- Administer corticosteroids
  - Methylprednisolone (solumedrol) 2mg/kg (max 125mg single dose) IV/IO
  - Oral prednisone if appropriate
- Croup:
  - Dexamethasone 0.6mg/kg IM/IV/IO
  - Racemic epinephrine 2.25% solution neb
    - <4 years old: 0.05mg/kg/dose diluted in 3mL NS over 15 minutes every 1-2 hours
    - >4 years old: 0.5mL/dose diluted in 3mL NS over 15 minutes every 1-2 hours
  - In the event that racemic epinephrine is not available, epinephrine 1:1000 can be used as a substitute. Use epinephrine 1:1000, 0.25-0.5mg/kg (max 5mL/dose) in 3mL and provide as a nebulizer over 15 minutes

REASSESS

Proceed to next page
Albuterol 1 hour continuous nebulizer
O 0.5mg/kg/hr (max 25mg/hr)
- Consider magnesium 25mg/kg (max 2gm)
  slow IV/IO infusion over 30 minutes
- Consider terbutaline
- Monitor closely for deterioration
- Obtain CXR if febrile
  - Consider antibiotics for suspected pneumonia

REASSESS

- Intubation if indicated
- Ventilator settings:
  - Tidal volume: 6-10mL/kg
  - I-t: 0.5-1.0
  - Respiratory rate: set based on age
  - PEEP: 3-5 mm H2O
  - Peak Inspiratory Pressure: 20-30 mm H2O
- For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition
- Admit patient
- Consult Pediatric Care Medical Specialist for assistance with individualizing admission orders
- Sample admission orders (see next page)

Poor, impending or actual respiratory arrest

No

Poor, minimal response to treatment

Yes

Albuterol 1 hour continuous nebulizer
O 0.5mg/kg/hr (max 25mg/hr)
- Monitor End Title CO2 (EtCO2) if possible/available
- Consider terbutaline
- Monitor closely for deterioration
- Obtain CXR if febrile
  - Consider antibiotics for suspected pneumonia

REASSESS

Yes

Improved, returned to baseline

Yes

- Observe for 1-2 hour
- Discharge if symptoms resolved and no signs of distress
- Follow up plan:
  - MDI with spacer 2-4 puffs every 4 hours as needed
  - Continue steroids

No

Improved, returned to baseline

Yes

- Intubation if indicated
- Ventilator settings:
  - Tidal volume: 6-10mL/kg
  - I-t: 0.5-1.0
  - Respiratory rate: set based on age
  - PEEP: 3-5 mm H2O
  - Peak Inspiratory Pressure: 20-30 mm H2O

Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

Admit patient
- Consult Pediatric Care Medical Specialist for assistance with individualizing admission orders
- Sample admission orders (see next page)

Poor, impending or actual respiratory arrest

No

Fair, slight improvement, not returned to baseline

Yes

Albuterol 1 hour continuous nebulizer
O 0.5mg/kg/hr (max 25mg/hr)
- Obtain CXR if febrile
  - Consider antibiotics for suspected pneumonia

REASSESS

No

Minimal response or fair/slight improvement but not returned to baseline

Yes

Improved, returned to baseline

Yes

- Observe for 1-2 hour
- Discharge if symptoms resolved and no signs of distress
- Follow up plan:
  - MDI with spacer 2-4 puffs every 4 hours as needed
  - Continue steroids

Poor, impending or actual respiratory arrest

No
Sample Pediatric Respiratory Admission Orders

Admitting physician: ____________________________________________________________

Diagnosis: ____________________________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg):__________________ Height(cm):__________________

Allergies: _________________________________________________________________

Pulse Oximetry:
- Obtain pulse oximetry on admission to unit
- If SpO₂ > 90%, obtain spot check pulse oximetry readings with each treatment, with vital signs or if patient exhibits decline in respiratory status
- If SpO₂ < 90%, provide oxygen and begin continuous pulse oximetry monitoring

Supplemental Oxygen Orders:
- If SpO₂ < 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain pulse oximetry >90%
- Wean oxygen if oxygen saturation maintains 94%.
  - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

□ Ventilator settings: ________________________________________________________
  - For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

Peak Expiratory Flow Rate (PEFR)
- Peak Flow will be done on admission for patients > 5 years of age to determine patient’s compliance/ability to effectively perform
- Check Peak Flow before and after breathing treatments.

AVERAGE PREDICTED PEAK EXPIRATORY FLOW RATES FOR NORMAL CHILDREN

<table>
<thead>
<tr>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>In</td>
<td>Cm</td>
<td></td>
<td>In</td>
<td>Cm</td>
<td></td>
<td>In</td>
<td>Cm</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>109</td>
<td>147</td>
<td>52</td>
<td>132</td>
<td>267</td>
<td>187</td>
<td>60</td>
<td>152</td>
</tr>
<tr>
<td>44</td>
<td>112</td>
<td>160</td>
<td>53</td>
<td>135</td>
<td>280</td>
<td>196</td>
<td>61</td>
<td>155</td>
</tr>
<tr>
<td>45</td>
<td>114</td>
<td>173</td>
<td>54</td>
<td>137</td>
<td>293</td>
<td>205</td>
<td>62</td>
<td>157</td>
</tr>
<tr>
<td>46</td>
<td>117</td>
<td>187</td>
<td>55</td>
<td>140</td>
<td>307</td>
<td>215</td>
<td>63</td>
<td>160</td>
</tr>
<tr>
<td>47</td>
<td>119</td>
<td>200</td>
<td>56</td>
<td>142</td>
<td>320</td>
<td>224</td>
<td>64</td>
<td>163</td>
</tr>
<tr>
<td>48</td>
<td>122</td>
<td>214</td>
<td>57</td>
<td>145</td>
<td>334</td>
<td>234</td>
<td>65</td>
<td>165</td>
</tr>
<tr>
<td>49</td>
<td>124</td>
<td>227</td>
<td>58</td>
<td>147</td>
<td>347</td>
<td>243</td>
<td>66</td>
<td>168</td>
</tr>
<tr>
<td>50</td>
<td>127</td>
<td>240</td>
<td>59</td>
<td>150</td>
<td>360</td>
<td>252</td>
<td>67</td>
<td>170</td>
</tr>
<tr>
<td>51</td>
<td>130</td>
<td>254</td>
<td>60</td>
<td>153</td>
<td>383</td>
<td>261</td>
<td>68</td>
<td>173</td>
</tr>
</tbody>
</table>

Medications:

☐ Albuterol
  ☐ MDI via spacer device
  ☐ 2 puffs every 3 hours (6-11 months old)
  ☐ 4 puffs every 3 hours (>12 months old)
  ☐ Nebulizer ______mg every ____ hrs (0.5mg/kg/hr, max dose 30mg/hr)
  ☐ Continuous
    ☐ If patient requires treatment prior to two hour interval, administer Albuterol continuous nebulizer for two hours and begin continuous pulse oximetry monitoring
    ☐ Albuterol 0.5mg/kg/hr (max dose 10mg/hr)

☐ Ipratropium bromide (Atrovent):
  ☐ 0.5mg to be given with 2nd and 3rd doses of Albuterol

☐ Corticosteroids:
  ☐ Prednisolone Sodium Phosphate (Orapred): ____mg PO STAT (2mg/kg loading dose-max 60mg/dose) then ____mg PO every 12 hours (1mg/kg maintenance dose-max 30mg/dose) x 5 days
  ☐ Methylprednisone (Solumedrol): ____mg IV STAT (2mg/kg loading dose-max 60mg/dose) then ____mg IV every 6 hours (1mg/kg maintenance dose-max 30mg/dose) x 4 doses

☐ Topical anesthetic for IV start and lab draws:
  ☐ Apply topically once 30-90 minutes prior to painful procedures (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)

☐ Antibiotics:
  ☐ ____________________________
  ☐ ____________________________
  ☐ ____________________________

☐ Fever/Pain Control
  ☐ Acetaminophen (Tylenol) (15mg/kg/dose)______mg PO/GT every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Acetaminophen (Tylenol) (20mg/kg/dose)______mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Ibuprofen (Motrin) (10mg/kg/dose)______mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort

☐ See Sample Pediatric Standard Admission Orders for additional examples for diet, IV, labs etc.

☐ Asthma Score (see below)
Unlike adults, cardiac arrest in children most often occurs secondary to respiratory insufficiency. Once the child proceeds to a cardiac event, the likelihood of resuscitating that child is dismal. Rapid airway assessment and intervention is imperative. Several conditions manifest as respiratory distress in children including: airway obstruction, upper airway disease (croup, epiglottitis), and lower airway disease (asthma, bronchiolitis, and pneumonia). Signs and symptoms of impending respiratory collapse include:

- Cyanosis
- Tachycardia
- Bradycardia
- Shallow respiration
- Decreasing LOC/restlessness
- Hypotension

Pediatric asthma may present differently from the adult form. Children may not wheeze, but continuously cough for 20-30 minutes after excitement or exercise, or may abruptly vomit.

Due to the small diameter of their airways, even incremental edema bronchoconstriction may cause severe air exchange problems. The inability of pediatric patients to increase their tidal-volumes often results in markedly increased respiratory rate which dehydrates airways and accelerates the development of mucous plugs. Hypoxemia & hypercarbia lead to acidosis and bradycardia. Treat aggressively.

**General Information**

**Asthma Score**

- Intended for use with patients > 2 years old who are being treated for asthma or an asthma exacerbation
- Not intended for patients who:
  - Are being treated for bronchiolitis, pneumonia, croup, reactive airway disease
  - Have chronic lung disease, cystic fibrosis, airway anomalies, cardiac disease, foreign body or neurologic disorders
  - Calculate the asthma score upon admission, prior to each aerosol treatment, and during the weaning process
- Wean if score of 0-1 and/or peak expiratory flow rate (PEFR) greater than 70% predicted → see Asthma Weaning Guidelines on next page.
- Treatment should be given for a score of 2 or higher and/or PEFR less than 70% predicted.

<table>
<thead>
<tr>
<th>ASTHMA SCORE</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory Rate (Count for a full minute)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-12 mos:</td>
<td>&lt; 40</td>
<td>0-12 mos:</td>
<td>40-50</td>
</tr>
<tr>
<td>1-5 y/o:</td>
<td>&lt; 30</td>
<td>1-5 y/o:</td>
<td>30-40</td>
</tr>
<tr>
<td>6-9 y/o:</td>
<td>&lt; 25</td>
<td>6-9 y/o:</td>
<td>25-30</td>
</tr>
<tr>
<td>&gt;15 y/o:</td>
<td>&lt; 20</td>
<td>&gt;15 y/o:</td>
<td>20-24</td>
</tr>
<tr>
<td><strong>Retractions</strong></td>
<td>None</td>
<td>Suprasternal/Subcostal/Intercostal</td>
<td>Using neck or abdominal muscles (belly breathing) if atypical for child</td>
</tr>
<tr>
<td><strong>Breath Sounds</strong></td>
<td>Normal, equal, Mild expiratory wheeze</td>
<td>Wheeze throughout expiration</td>
<td>Wheeze throughout inspiration &amp; expiration Multiple areas with decreased breath sounds</td>
</tr>
<tr>
<td><strong>Oxygen Saturation (SpO₂)</strong></td>
<td>≥ 92%</td>
<td>≥ 90-92%</td>
<td>≤ 90%</td>
</tr>
</tbody>
</table>

Adapted from: Cincinnati Children’s Hospital Medical Center Respiratory Assessment/Care Record, 2002; Kelly et al, Improved Outcomes for Hospitalized Asthmatic Children Using a Clinical Pathway, 2000.
### Asthma Weaning Phases

**NOTE:** Initial asthma phase should be chosen on the patient’s clinical presentation (e.g., the frequency of initial treatments needed to show improvement), with some assistance with asthma score. For example, a patient with asthma score of 2-3 would likely start in phase II or III. If patient has an asthma score of 4 or more, consider starting patient in phase I or II.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
</table>
| **PHASE I:** Continuous Albuterol treatment | • Assess Asthma Score every 1-2 hours  
• If score less than 2 for two consecutive assessments, wean to Phase II  
• If worsening score or has not met weaning criteria after 6 hours, RT to call physician |
| **PHASE II:** Every 2 hour Albuterol treatment | • Assess Asthma Score before and after every treatment  
• If score less than 2, wean to Phase III  
• If worsening score (score increased by 2 or more) or has not met weaning criteria after 8 hours, RT to call physician |
| **PHASE III:** Every 3 hour Albuterol treatment | • Assess Asthma Score before and after every treatment  
• Transition to MDI with spacer +/- mask or mouthpiece if able to comply  
  ○ **ALL MDI ALBUTEROL IS 4-6 PUFFS PER TREATMENT (in 30 second intervals)**  
• If score less than 2, wean to Phase IV  
• If worsening score (score increased by 2 or more) or has not met weaning criteria after 12 hours, RT to call physician |
| **PHASE IV:** Every 4 hour Albuterol treatment | • Assess Asthma Score before and after every treatment  
• If worsening score (score increased by 2 or more) or has not met discharge criteria after 12 hours, RT to call physician  
• If patient has met discharge criteria after 2 beta-agonist treatments at q 4 hours, RT to call physician |

**Discharge Criteria: Must meet all 5 discharge criteria**

1. SpO2 > 92% (goal = 91-94%)  
2. Off of supplemental oxygen for at least 6 hours (must include one sleep period—this may be a nap*)  
3. Normal respiratory rate  
4. End expiratory wheeze only  
5. Minimal → no retractions

*A nap is at least 30 continuous minutes of sleep
Initial Management of All Pediatric Shock Patients

- Stabilize ABCs and c-spine (Airway, Breathing, and Circulation)
- Obtain weight (actual or use of weight/length based tool)
- Establish 2 peripheral IVs (consider large bore if possible) or if unable, establish intraosseous (IO) access
- Control any external bleeding
- Monitor
  - Heart Rate (HR), Blood pressure (BP), Oxygen Saturation (SpO₂), mental status, temperature, perfusion, urine output, bedside glucose
- Perform history & physical exam
- Consult Pediatric Care Medical Specialist for assistance with care of the acutely and critically ill patient, to individualize the care of patient, if patient does not improve and needs to be admitted/transferred and as needed for further support and consult.

Management of all Pediatric Shock Patients

Does patient have signs of organ dysfunction?

YES

- Hypotension
  - < 2 y/o Systolic BP (SBP) < 70 mmHg
  - 2-10 y/o SBP < (70+2 x age in years)
  - >10 y/o SBP < 90 mmHg
- All ages: Diastolic BP (DBP) < 30 mmHg
- Capillary refill > 2 seconds
- Witnessed apnea
- Need for FiO₂ > than 0.50 to maintain SpO₂ > 92
- Altered mental status
- Consult pediatric care medical specialist

REASSESS

NO

Begin IVF bolus (0.9 NS) 20mL/kg over 15 minutes or as fast as possible. Repeat x 1
- Consider need for intubation
- If cardiogenic shock suspected, administer IVF boluses at a rate of 5-10mL/kg over 10-20 minutes. Repeat PRN. Assess for pulmonary edema after each bolus
- Draw labs (blood gas, glucose, CBC, CMP, PT/PTT, lactic acid, blood culture, Type and Screen)

REASSESS

NO

0 ≤ 40mL/kg IVF given?

YES

- Monitor vital signs & perform perfusion checks q 1 hr x 2
- Maintenance IVF
- Ongoing assessment: monitor for hypothermia and hypoglycemia
- Determine and treat cause (see Determine and Treat Cause Section for additional information)

NO

Give IVF bolus (0.9NS) 20mL/kg over 15 minutes or as fast as possible. Repeat x 1
- Perform vital signs, perfusion and neuro checks q15mins
- If cardiogenic shock suspected, administer IVF boluses (0.9NS) at a rate of 5-10mL/kg over 10-20 minutes. Repeat PRN. Assess for pulmonary edema after each bolus
- Draw labs (blood gas, glucose, CBC, CMP, PT/PTT, lactic acid, blood culture, Type and Screen)

Proceed to next page
Fluid refractory/Dopamine Resistant
- If SpO₂ Sat<70%, hypotensive, and poor perfusion/vasoconstricted:
  - Transfuse with PRBCs if Hgb<10 (10mL/kg)
  - Epinephrine 0.1-1mcg/kg/min OR
  - Dobutamine 2-20mcg/kg/min
- If SpO₂ Sat>70%, hypotensive, and vasodilated:
  - Norepinephrine 0.1-2mcg/kg/min

REASSESS
- If at risk for adrenal insufficiency:
  - Hydrocortisone 2mg/kg bolus IV (max 100mg)
- If SpO₂ Sat<70%, normal blood pressure, and/or poor perfusion/vasoconstricted:
  - Nitroprusside OR
  - Milrinone
- If SpO₂ Sat<70% and hypotensive:
  - Titrate IVF
  - Continue Epinephrine
- If SpO₂ Sat>70% and hypotensive:
  - Titrate IVF
  - Continue Norepinephrine

REASSESS
- Administer IVF bolus (0.9NS) 20mL/kg over 15 minutes or as fast as possible
- Assess for clinical or laboratory signs of organ dysfunction:
  - Metabolic: base deficit > 5 (BE< -5); lactate > 2X upper limit of normal
  - Respiratory: PaO₂/FiO₂<300; PCO₂>65 or greater than 20 above baseline
  - Hematologic: Platelets <80K (unexplained); INR>2
  - Renal: Creatinine > 2X upper limit of normal; oliguria<0.5mL/kg/hr
  - Hepatic: total bilirubin>4; AST> 2X upper limit of normal

REASSESS
- If SpO₂ Sat<70%, hypotensive, and poor perfusion/
  - Transfuse with PRBCs if Hgb<10 (10mL/kg)
  - Epinephrine 0.1-1mcg/kg/min OR
  - Dobutamine 2-20mcg/kg/min
- If SpO₂ Sat>70%, hypotensive, and vasodilated:
  - Norepinephrine 0.1-2mcg/kg/min

REASSESS
- Monitor vital signs & perform perfusion checks q 1 hr x 2
- Ongoing assessment: monitor for hypothermia and hypoglycemia
- Maintenance IVF
- Consult pediatric care medical specialist
- Determine and treat cause (see Determine and Treat Cause Section)
- Admit patient (see sample admission orders):
  - Sepsis (see pg 4)
  - Hypovolemia (see pg 7)

REASSESS
- Improved, normalized AND ≥ 40mL/kg IVF given
- Improved and/or normalized
- Improved and/or normalized
- Improved and/or normalized
- Improved and/or normalized
- Improved and/or normalized
### Determine and treat cause

#### Anaphylaxis:
- Epinephrine 1:1000 0.1mL/kg (not to exceed 0.3 mg/dose) IM, every 15 minutes x 2 then every 4 hours OR
- Epinephrine Autoinjector 0.3mg IM (for patients>30kg) OR Junior Autoinjector 0.15mg (for patients 10-30kg) OR
- If hypotension continues after IVF bolus, Epinephrine 0.01mg/kg (1:10000) IV/IO every 3-5 minutes (max dose 1mg)
- Benadryl 1.25-1.5mg/kg IV/IO/IM every 4-6 hours (max dose 50mg)
  - Monitor for respiratory depression
- Methylprednisone 2mg/kg IV/IO initially (max 60mg) then 0.5mg/kg every 6 hours or 1mg/kg every 12 hours (max 125mg/day).
- Pepcid 0.5mg/kg IV every 12 hours

#### Cardiogenic shock:
- Administer IVF boluses at a rate of 5-10mL/kg over 10-20 minutes. Repeat PRN. Assess for pulmonary edema after each bolus.
- Consider Diuretics
- Consider Milrinone
- Consider need to increase cardiac output
  - Vasodilators
  - Inotropes
- Reduce metabolic demands:
  - Antipyretics/analgesics PRN

#### Hemorrhage:
- If signs/symptoms of shock and at risk for hemorrhage, consider administering PRBCs 10mL/kg
  - Administering 10mL/kg of PRBCs will increase hemoglobin by 2g/dL or hematocrit 4-6%

#### Hypocalcemia
- Calcium chloride: 10-20mg/kg (0.1-0.2mL/kg calcium chloride 10%) IV/IO infused at a rate that does not exceed 100mg/min OR

#### Hypoglycemia
- Birth-28 days: D10W 2mL/kg IV/IO
- >28 days-1 year: D12.5% 4-8mL/kg IV/IO
- >1 year: D25% 2-4mL/kg IV/IO
- D50% 1-2mL/kg IV/IO

#### Obstructive shock:
Treat underline cause:
- Cardiac Tamponade (perform pericardiocentesis if experienced/skilled practioner available)
- Tension Pneumothorax (perform needle decompression and place chest tube if experienced/skilled practitioner available)
- Closed ductus arteriosus
  - Prostaglandin E1 0.05-0.1mcg/kg/min continuous IV/IO
- Pulmonary embolism

#### Spinal cord injury:
If hypotensive/bradycardic after IVF boluses:
- Atropine 0.02 mg/kg IV/IO (min single dose 0.1mg/max single dose 1mg). May repeat every 3 minutes to max 2mg.
If continue to be hypotensive and bradycardic:
- Dopamine to maintain SBP >90
- Phenytoin or vasopressin
- Consult neuro surgeon for further medical management

#### Sepsis:
- Antibiotics: broad spectrum antimicrobial agent
  - Neonates: Ampicillin and Cefotaxime OR Ampicillin and Gentamicin
- Antipyretics
Sample Pediatric Septic Shock Admission Orders

Admitting physician: __________________________________________

Diagnosis: ____________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg): __________ Height (cm): __________

Allergies: _____________________________________________________

Isolation: _____________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O
□ Daily weight
□ Seizure precautions
□ Neuro checks ever _____ hours
□ All non-rectal temperatures > 38°C/100.4°F should be confirmed rectally on infants ≤60 days of age

Tests:
□ CBC with differential
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours
□ CMP
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours
□ BMP
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours
□ Blood culture (order if not performed prior to admission)
□ Viral blood culture
□ Catheterized urinalysis (order if not performed prior to admission)
□ Catheterized urine culture (order if not performed prior to admission)
□ Stool culture
□ Stool for Rotavirus
□ Stool gram stain
□ RSV
□ Influenza
□ Viral culture
□ Chest x-ray (PA and lateral) (order if not performed prior to admission)
For infants ≤60 days of age with fever:
   □ CSF for (laboratory should perform these in ranking order as listed below)
      □ Cell count
      □ Glucose
Protein
Gram stain
Aerobic culture
Viral culture
Enterovirus PCR
Herpes PCR
Meningitis antigen profile
Conjunctiva viral culture
Viral culture of skin lesion on __________________
Rectal viral culture

Medications:
☐ Fever/Pain Control:
  ☐ Acetaminophen (Tylenol) (15mg/kg/dose) ______ mg PO/GT every 4 hrs PRN for
    temperature 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Acetaminophen (Tylenol) (20mg/kg/dose) ______ mg PR every 4 hrs PRN for temperature ≥
    38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Ibuprofen (Motrin) (10mg/kg/dose) ______ mg PO/GT every 6 hours PRN for temperature
    ≥ 38.6°C/101.5°F or discomfort (for infants >5 months)
☐ Antibiotics:
  ☐ Ceftriaxone ______ mg IV every _____ hours (max 4gm/day)
  ☐ Vancomycin _____ mg IV every _____ hours (max 1gm/dose)
  ☐ __________________________
  ☐ __________________________
  ☐ __________________________
  ☐ For infants ≤60 days of age with fever:
    ☐ Ampicillin _________ mg IV every 6 hours (200 mg/kg/day)
    ☐ Cefuroxime ____________ mg IV every 6 hours (200 mg/kg/day)
    ☐ Acyclovir ____________ mg IV every _____ hours
      (If greater than or equal to 35 weeks post-conceptual age, give 60 mg/kg/day divided
      every 8 hours. If less than 35 weeks post conceptual age, give 40 mg/kg/day divided
      every 12 hours)
    ☐ Gentamycin _________ mg IV every _____ hours
☐ Topical anesthetic for IV start and lab draws:
  ☐ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area
    squared, or application time of 2 hours)

IV Therapy:
☐ Saline lock
☐ D5 ½ NS with 20 mEq KCl/L running at _____ mL/hr (ensure patient is voiding)
☐ __________________________ running at _____ mL/hr
☐ __________________________ running at _____ mL/hr

Supplemental Oxygen Orders:
  • If SpO2 < 90% on room air, apply oxygen to maintain SpO2 91-94%
    ☐ Nasal Cannula
- Aerosol Mask
  - Titrate oxygen to maintain $\text{SpO}_2$ > 90%
  - Wean oxygen if oxygen saturation maintains 94%.
    - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
    - Do not decrease oxygen more frequently than every 60 minutes

- Ventilator Settings: __________________________
  - For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

- See Sample Pediatric Standard Admission Orders for additional examples for diet, IV, labs etc
Sample Pediatric Hypovolemic Shock Admission Orders

Admitting physician: ____________________________________________________________

Diagnosis: ___________________________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg): ____________________ Height(cm): ____________________

Allergies: ___________________________________________________________________

Isolation: __________________________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O
□ Daily weight

Tests:
□ CBC with differential
  □ now (order if not performed prior to admission)
  □ at _____
  □ every _____ hours

□ CMP
  □ now (order if not performed prior to admission)
  □ at _____
  □ every _____ hours

□ BMP
  □ now (order if not performed prior to admission)
  □ at _____
  □ every _____ hours

Medications:
□ Fever/Pain Control:
  □ Acetaminophen (Tylenol) (15mg/kg/dose)_________mg PO/GT every 4 hrs PRN for temperature ≥38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Acetaminophen (Tylenol) (20mg/kg/dose)_________mg PR every 4 hrs PRN for temperature ≥38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Ibuprofen (Motrin) (10mg/kg/dose)_________mg PO/GT every 6 hours PRN for temperature ≥38.6°C/101.5°F or discomfort (for infants >5 months)

□ Antiemetic:
  □ _____________________________________________________________________________
  □ _____________________________________________________________________________

□ Antibiotics:
  □ _____________________________________________________________________________
  □ _____________________________________________________________________________
  □ _____________________________________________________________________________

□ Topical anesthetic for IV start and lab draws:
☐ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)

**IV Therapy:**

☐ ________________ running at ______ mL/hr (ensure patient is voiding)

☐ D5 ½ NS with 20 mEq KCl/L running at ______ mL/hr

☐ ________________ running at ______ mL/hr

☐ ________________ running at ______ mL/hr

**Supplemental Oxygen Orders:**

- If SpO$_2$ < 90% on room air, apply oxygen to maintain SpO$_2$ 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain SpO$_2$ >90%
- Wean oxygen if oxygen saturation maintains 94%.
  - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

**Ventilator Settings:**

- For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

☐ See **Sample Pediatric Standard Admission Orders** for additional examples for diet, IV, labs etc
# Definitions and Other Pediatric Shock Information

## TYPES

### Distributive Shock

*Definition:* Excessive vasodilation and impaired distribution of blood flow  
*Common types:* Sepsis, anaphylaxis, spinal cord injuries (neurogenic)

### Hypovolemic Shock

*Definition:* Deficiency of intravascular blood volume  
*Common causes:*
   1. Intravascular volume loss: gastroenteritis, burns, diabetes insipidus, heat stroke
   2. Hemorrhage: trauma, surgery
   3. Interstitial loss: burns, sepsis, nephrotic syndrome, intestinal obstruction, ascites

### Obstructive Shock

*Definition:* Circulatory failure caused by a physical obstruction  
*Common causes:* Physical causes of shock should be considered (e.g. cardiac Tamponade or pulmonary embolism), especially in neonates who may have been born with obstructive congenital heart disease (i.e. coarctation of the aorta, severe aortic valvular stenosis)  
*Presentation:* Neonates who present with signs of shock associated with enlarged liver, enlarged cardiac silhouette and/or heart murmur

### Cardiogenic Shock

*Definition:* Impaired cardiac contractility  
*Common causes:*
   1. Congestive heart failure
   2. Cardiomyopathy
   3. Cardiac Tamponade
   4. Drugs
   5. Tension Pneumothorax

## Key Points

### Stages of shock:

- Compensated, Decompensated & Irreversible
  - Tachycardia=Compensated
  - Progression to next stage can be abrupt
  - Adolescents compensate like kids, not adults
  - Hypotension= Decompensated

### Early indicators of shock

- Hyperthermia/hypothermia, leukocytosis/neutropenia, unexplained tachycardia, tachypnea, poor distal perfusion
<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>DISORDERS</th>
<th>GOALS</th>
<th>THERAPIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>Acute respiratory distress syndrome</td>
<td>Prevent/treat: hypoxia and respiratory acidosis</td>
<td>Oxygen</td>
</tr>
<tr>
<td></td>
<td>Respiratory muscle fatigue</td>
<td>Prevent barotrauma</td>
<td>Early endotracheal intubation and mechanical ventilation</td>
</tr>
<tr>
<td></td>
<td>Central apnea</td>
<td>Decrease work of breathing</td>
<td>Positive end-expiratory pressure (PEEP) Permissive hypercapnia High-frequency ventilation Extracorporeal membrane oxygenation (ECMO)</td>
</tr>
<tr>
<td>Renal</td>
<td>Pre-renal failure</td>
<td>Prevent/treat: hypovolemia, hypervolemia, hyperkalemia, metabolic acidosis, hypernatremia/ hyponatremia, and hypertension</td>
<td>Judicious fluid resuscitation Low-dose dopamine Establishment of normal urine output and blood pressure for age Furosemide (Lasix) Dialysis, ultrafiltration, hemofiltration</td>
</tr>
<tr>
<td></td>
<td>Renal failure</td>
<td>Monitor serum electrolytes</td>
<td>Vitamin K Fresh frozen plasma Platelets</td>
</tr>
<tr>
<td>Hematologic</td>
<td>Coagulopathy (disseminated intravascular coagulation)</td>
<td>Prevent/treat: bleeding</td>
<td>Heparinization Activated protein C</td>
</tr>
<tr>
<td></td>
<td>Thrombosis</td>
<td>Prevent/treat: abnormal clotting</td>
<td>Histamine H2 receptor–blocking agents or proton pump inhibitors Nasogastric tube</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Stress ulcers</td>
<td>Prevent/treat: gastric bleeding Avoid aspiration, abdominal distention</td>
<td>Early enteral feedings</td>
</tr>
<tr>
<td></td>
<td>Ileus</td>
<td>Avoid mucosal atrophy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bacterial translocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>Adrenal insufficiency, primary or secondary to chronic steroid therapy</td>
<td>Prevent/treat: adrenal crisis</td>
<td>Stress-dose steroids in patients previously given steroids Physiologic dose for presumed primary insufficiency in sepsis</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Metabolic acidosis</td>
<td>Correct etiology Normalize pH</td>
<td>Treatment of hypovolemia (fluids), poor cardiac function (fluids, inotropic agents) Improvement of renal acid excretion Low-dose (0.5-2 mEq/kg) sodium bicarbonate if the patient is not showing response, pH &lt; 7.1, and ventilation (CO2 elimination) is adequate</td>
</tr>
</tbody>
</table>
Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.

Disclaimer: This guideline is not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Initial Management of All Pediatric Trauma Patients

- Stabilize ABCs and c-spine (Airway, Breathing, and Circulation)
  - IMMOBILIZE SPINE as indicated. Position for optimal airway and suction as needed. Position infants and children < 2 yrs supine on a backboard with a recess for the head or use a pad under the back from the shoulders to the buttocks.
  - Consider needle decompression for signs of pneumothorax, hemothorax or tension pneumothorax
- Obtain weight (actual or use of weight/length based tool)
- Establish 2 peripheral IVs (consider large bore if possible) or if unable, establish intraosseous (IO) access
- Control any external bleeding
- Avoid removal of penetrating objects in the emergency department (should be performed in operating room due to risk of hemorrhage)
- Monitor
  - Heart Rate (HR), Blood pressure (BP), Oxygen Saturation (SpO₂), mental status, temperature, perfusion, urine output, bedside glucose
- Perform detailed primary and secondary history & physical exam including mechanism of injury, Pediatric Trauma Score (PTS) and Pediatric Glasgow Coma Scale (PGCS)
- Consult pediatric care medical specialist for assistance with care of the acutely and critically injured patient (see below for Level I Trauma Criteria), to individualize the care of patient, if patient does not improve and needs to be admitted/ transferred and as needed for further support and consult.

- Category 1 Trauma Criteria (minimum):
  - All penetrating injuries to head, neck, torso, and/or groin
  - Two or more body regions with potential threat to life or limb
  - Combination trauma with ≥20% TBSA burn
  - Limb paralysis and/or sensory deficit above the wrist and ankle
  - Flail chest
  - Amputation proximal to wrist or ankle
  - Blunt or penetrating trauma with unstable vital signs AND/OR:
    - Hemodynamic compromise (Pediatric SBP≤80)
    - Respiratory compromised (Respiratory rate <10 or >29)
    - Altered mentation (PGCS≤10)

- Additional Blast Injury Considerations:
  - Classification of Blast Injuries (see page 8 for more detailed information on pediatric clinical presentations for common blast injuries and management of specific blast injuries)
    - Primary
      - Results from impact of the over-pressurized blast wave
      - Gas filled/ hollow structures most susceptible
      - Examples: blast lung, tympanic membrane rupture, abdominal hemorrhage and perforation, eye globe rupture, traumatic brain injury (TBI) without physical signs of head injury
    - Secondary
      - Results from flying debris and bomb fragments
      - Entire body may be affected
      - Examples: penetrating and blunt trauma injuries, eye penetration
- Tertiary
  - Results from victims being thrown by blast wind
  - Entire body may be affected
  - Examples: fractures, amputations, closed and open brain injury
- Quaternary
  - All injuries, illnesses not due to Primary, Secondary or Tertiary mechanisms
  - Entire body may be affected
  - Example: crush injuries, burns, asphyxia, toxic exposures, exacerbation or complications from existing or chronic conditions
Management for Pediatric Trauma & Blast Injury Patients

Determine if patient is critically ill/injured

- Capillary refill >2 seconds
- Slow or fast breathing rate
- Penetrating wound to head/chest/abdomen
- Significant blunt trauma to chest/abdomen
- Pelvic/femoral fracture
- Open chest wound
- Spinal injury with paresthesia
- Unconscious/history of LOC
- Amputation/crush injury
- Respiratory distress/failure
- Signs/symptoms of intra-abdominal injury:
  - Hematuria, Grey Turner sign (discoloration of flank/periumbilical area), abdominal asymmetry/distention, tender/guarding/pain on palpation
- Signs of Shock
- Prolonged extrication

YES

Treat all life threatening injuries:
- Protect airway:
  - Apply supplemental oxygen to maintain SpO$_2$ ≥ 94%
  - Use NPA/OPA as needed if not contraindicated
  - Intubated as needed to protect airway
    - Tidal volume: 6-10mL/kg
    - I-time: 0.5-1.0
  - Respiratory rate: set based on age
  - PEEP: 3-5 mm H2O
  - Peak Inspiratory Pressure: 20-30 mm H2O
  - For more information, see: *Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition*
  - Control any bleeding
  - Administer 0.9NS IVF bolus 20mL/kg if signs of hypoperfusion exist. Repeat x 2 PRN
  - Consider PRBCs if patient does not respond to IVF boluses (10mL/kg)
- Perform x-rays, CTs as indicated:
  - Immobilize/splint/stabilize any fractures
- Draw labs as indicated (CBC, CMP, PT/PTT, urine analysis, Type and Screen)
- Initiate pain control
- Administer antibiotics and tetanus as indicated
- Perform detailed head to toe assessment (see pg. 7 for details)

Additional Blast Injury Considerations:
- See page 8 for detailed assessment and management for blast injuries
- Maintain urine output of 2-4mL/kg/hr
- Prolonged extrication requires high fluid volume and possible alkanization of the urine
- For potential potential rhabdomylosis (0.45% NS with 50mEq/liter of sodium bicarbonate).
- Monitor urine for RBCs and myoglobin
- Obtain CKMB, ECG and maintain cardiac monitor
- Consider compartment syndrome if pain disproportionate to injury
- Consider performing a fasciotomy (if experienced/skilled practitioner available or after...
- Administer 0.9NS IVF bolus 20mL/kg x 1 PRN
  - Perform x-rays, CTs and labs as indicated by injuries.
- Immobilize and splint and identified fractures
  - Check for growth plate involvement
  - C-Spine x-rays NOT required if (per ATLS Guidelines):
    - No neck pain or palpable tenderness AND
    - No distraction injury AND
    - GCS 15 AND
    - Not intoxicated or under influence of drugs
- Assess circulation, movement and sensation (CMS) and neuro checks every 2 hours as indicated
- Pain control as needed (consider pharmacological and non-pharmacological pain control measures)
- Blast injury Considerations:
  - Monitor urine for RBCs and myoglobin
  - Obtain ECG if indicated
  - Maintain urine output of 2-4mL/kg/hr

Reassess

Worse, not improved or not normalized, or improved but not normalized

- Repeat 0.9NS IVF bolus 20mL/kg x 2 PRN
- Consult with pediatric care medical specialist for possible transfer
- Monitor CMS, neuro status and vital signs every 2-4 hours
- Admit patient
- See Sample admission orders (pg. 5)

Reassess

Worse, not improved or not normalized

Improved

Monitor for 6-8 hours and if:
- Stable vital signs AND
- Neuro status appropriate for age AND
- CMS intact AND
- Serial exams AND
  - Discharge with appropriate follow up instructions

Worse, not improved or not normalized
Sample Pediatric Trauma/Blast Injury Admission Orders

**Admitting physician:**

**Diagnosis:**

**Condition:** □ Critical □ Serious □ Stable

**Weight (kg):**__________________ **Height (cm):**__________________

**Allergies:**

**Assessment:**

□ Continuous cardiac monitoring

□ Continuous pulse oximetry

□ Blood pressure with all vital signs

□ Routine I&O

□ Strict I&O q 1 hour (maintain urine output at 2-4mL/kg/hr)

□ Daily weight

□ Seizure precautions

□ Neuro checks ever_____ hours

□ Perform CMS checks on extremities every ____ hours to monitor for compartment syndrome/crush syndrome

**Tests:**

**Medications:**

□ Fever/Pain Control:

□ Acetaminophen (Tylenol) (15mg/kg/dose)________mg PO/GT every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)

□ Acetaminophen (Tylenol) (20mg/kg/dose)________mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)

□ Ibuprofen (Motrin) (10mg/kg/dose) _________mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort (for infants >5 months). Ensure adequate renal function before utilizing.

□ Morphine (0.1-0.2 mg/kg) _____ mg IV every 2-4 hours as needed (max 10mg/dose)

□ Fentanyl _______mg IV every ______hours as needed.

□ Antibiotics:

□ __________________________________________________________________________

□ __________________________________________________________________________

□ Topical anesthetic for IV start and lab draws

□ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)

**IV Therapy:**

□ Saline Lock

□ NS bolus ________ mL IV to run over 1 – 2 hours

□ LR bolus ________mL IV to run over 1-2 hours

□ D5 0.45 NS with 20 mEq KCl/L to run at _________mL/hr (Ensure adequate renal function before utilizing potassium)
Supplemental Oxygen Orders:

- If \(\text{SpO}_2\) < 90% on room air, apply oxygen to maintain \(\text{SpO}_2\) 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain \(\text{SpO}_2\) >90%
- Wean oxygen if \(\text{SpO}_2\) maintains 94%.
  - Decrease oxygen by \(\frac{1}{2}\) liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

Ventilator Settings:

For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

See Sample Pediatric Standard Admission Orders for additional examples for diet, IV, labs etc

If hypovolemic, refer to Pediatric Shock Care Guidelines: Sample Hypovolemic Shock Admission Orders
Detailed Assessment of Pediatric Trauma Patients

- Inspect/palpate each body area for DCAP-BLS, TIC, PMS (Deformity, contusions, abrasions, punctures, burns, lacerations, swelling, tenderness, instability, crepitus; + pulses, motor, and sensory ability) as appropriate plus:

- MENTAL STATUS: Assess mentation using the Pediatric Glasgow Coma Scale (PGCS), Neuro exam, motor/sensory, nuchal rigidity, appearance, tone, acting appropriate for age, consolability, look/gaze, and speech/cry.

- HEAD, FACE, EYES, EARS, NOSE, MOUTH: Note any drainage; re-inspect pupils for size, shape, equality, fixed deviation and reactivity; conjugate movements; note gross visual acuity

- NECK: Carotid pulses, neck veins, subcutaneous (Sub-Q) emphysema, location of trachea, and cervical spines

- CHEST: Expose chest as needed. Auscultate breath/heart sounds.

- RESPIRATION/VENTILLATION: rate, rhythm, pattern and work of breathing

- ABDOMEN: Signs of injury/peritonitis. Note contour, visible pulsations, wounds/bruising patterns, pain referral sites, localized tenderness, guarding, rigidity

- PELVIS/GU: Inspect perineum and apply PASG/mast trousers if suspected pelvic fracture.

- EXTREMITIES: Inspect for position, false motion, skin color, and signs of injury

- BACK: Note any muscle spasms

- SKIN/SOFT TISSUE: Inspect/palpate for color, temperature, moisture, signs of SQ emphysema, pulses in all extremities, capillary refill

### Pediatric Trauma Score (age 12 and under)

<table>
<thead>
<tr>
<th>Component</th>
<th>+2</th>
<th>+1</th>
<th>-1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 20kg</td>
<td></td>
<td>11-20kg</td>
<td>≤ 10kg</td>
</tr>
<tr>
<td>&gt; 5 years old</td>
<td></td>
<td>1-5 years old</td>
<td>&lt; 1 year old</td>
</tr>
<tr>
<td><strong>Airway</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td>Maintainable</td>
<td>Unmaintained or intubated</td>
</tr>
<tr>
<td>Systolic BP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;90mmHg</td>
<td></td>
<td>50-90mmHg</td>
<td>&lt; 50 mmHg</td>
</tr>
<tr>
<td><strong>CNS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awake</td>
<td></td>
<td>Obtunded/lost consciousness</td>
<td>Coma/unresponsive</td>
</tr>
<tr>
<td><strong>Skeletal Injury</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>Closed fracture</td>
<td>Open/multiple fractures</td>
</tr>
<tr>
<td><strong>Open Wounds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>Minor</td>
<td>Major/penetrating</td>
</tr>
</tbody>
</table>

Score of < 8 usually indicates the need for evaluation at a Trauma Center.

### Pediatric Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Category</th>
<th>For Patients &lt;2 Years Old</th>
<th>For Patients &gt;2 Years Old</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Opening (E)</strong></td>
<td>(4) Spontaneous</td>
<td>(4) Spontaneous</td>
</tr>
<tr>
<td></td>
<td>(3) To speech</td>
<td>(3) To speech</td>
</tr>
<tr>
<td></td>
<td>(2) To pain</td>
<td>(2) To pain</td>
</tr>
<tr>
<td></td>
<td>(1) None</td>
<td>(1) None</td>
</tr>
<tr>
<td><strong>Verbal Response (V)</strong></td>
<td>(5) Coos, babbles, appropriate words</td>
<td>(5) Oriented</td>
</tr>
<tr>
<td></td>
<td>(4) Irritable, cries</td>
<td>(4) Confused</td>
</tr>
<tr>
<td></td>
<td>(3) Cries to pain</td>
<td>(3) Inappropriate words</td>
</tr>
<tr>
<td></td>
<td>(2) Moans to pain</td>
<td>(2) Incomprehensible</td>
</tr>
<tr>
<td></td>
<td>(1) None</td>
<td>(1) None</td>
</tr>
<tr>
<td><strong>Motor Response (M)</strong></td>
<td>(6) Normal spontaneous movements</td>
<td>(6) Obeys commands</td>
</tr>
<tr>
<td></td>
<td>(5) Withdraws from touch</td>
<td>(5) Localizes to pain</td>
</tr>
<tr>
<td></td>
<td>(4) Withdraws from pain</td>
<td>(4) Withdrawal to pain</td>
</tr>
<tr>
<td></td>
<td>(3) Abnormal flexion (deco)</td>
<td>(3) Flexion to pain</td>
</tr>
<tr>
<td></td>
<td>(2) Abnormal extension (decerebrate)</td>
<td>(2) Extension to pain</td>
</tr>
<tr>
<td></td>
<td>(1) None</td>
<td>(1) None</td>
</tr>
</tbody>
</table>
**IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex**  
**Trauma and Blast Injury Care Guideline 2015**

**Purpose:** To provide guidance to practitioners caring for pediatric patients during a disaster.  
**Disclaimer:** This guideline is not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

---

**Detailed Assessment and Management of Blast Injury**  

<table>
<thead>
<tr>
<th>Type of Injury</th>
<th>Presentation</th>
<th>Diagnosis</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal injury</td>
<td>• Injury presentation may be subtle and variable</td>
<td>• Similar to standard abdominal trauma</td>
<td>• NPO</td>
</tr>
<tr>
<td></td>
<td>• Signs/symptoms: abdominal pain, rebound tenderness, absent bowel sounds,</td>
<td>• Serial abdominal exams</td>
<td>• Avoid removal of penetrating objects in the emergency department</td>
</tr>
<tr>
<td></td>
<td>nausea, vomiting, fever and signs of hypovolemia or hemorrhage</td>
<td>• Laboratory tests</td>
<td>(perform in OR)</td>
</tr>
<tr>
<td></td>
<td>• Injuries following underwater blasts have increased severity</td>
<td>• Radiology tests: free air, unexplained ileus, intra-abdominal hematoma/</td>
<td>• Antibiotics, tetanus vaccination</td>
</tr>
<tr>
<td></td>
<td><strong>Pediatric Considerations:</strong></td>
<td>hemorrhage, solid organ contusion/laceration, intra-abdominal abscess</td>
<td>• Serial exams and laboratory monitoring</td>
</tr>
<tr>
<td></td>
<td>o Smaller and more pliable ribs and thinner abdominal walls leaves</td>
<td></td>
<td>• Women in 2\textsuperscript{nd} and 3\textsuperscript{rd} trimester should have fetal monitoring</td>
</tr>
<tr>
<td></td>
<td>abdominal organs unprotected so children are more prone to abdominal</td>
<td></td>
<td>• All pregnant women should have a Kleihauer-Betke test:</td>
</tr>
<tr>
<td></td>
<td>injuries</td>
<td></td>
<td>o Positive requires mandatory pelvic ultrasound, fetal non-stress test monitoring and OB/GYNE consult</td>
</tr>
<tr>
<td></td>
<td>o Proportionally, children have larger organs so they are more prone to</td>
<td></td>
<td>• Radiology exams: plain abdominal films, CT scan, Focused Abdominal</td>
</tr>
<tr>
<td></td>
<td>injury</td>
<td></td>
<td>Sonography for Trauma (FAST)</td>
</tr>
<tr>
<td></td>
<td>o Spleen and liver are especially more vulnerable to injury from blunt</td>
<td></td>
<td>• Appropriate referral to trauma center as applicable</td>
</tr>
<tr>
<td></td>
<td>and penetrating force trauma.</td>
<td></td>
<td>• Strict discharge and return instructions if signs/symptoms of abdominal</td>
</tr>
<tr>
<td></td>
<td>o Traumatic asphyxia results from sudden compression of the abdomen</td>
<td></td>
<td>injury occur after discharge</td>
</tr>
<tr>
<td></td>
<td>or chest against a closed glottis. Symptoms include: hyperemic sclera,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>seizures, disorientation, petechiae on upper body, respiratory failure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment is supportive.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Illinois EMSC  
www.luhs.org/emsc
### Brain/ Neurological/ Cervical Injury

- Head injury is most common cause of death in bombings
- Diffuse axonal injury, skull fractures, coup-counter-coup injury, subarachnoid and subdural hemorrhage common
- Mild Traumatic Brain Injury (mTBI) may go undiagnosed or misdiagnosed as PTSD
- May or may not have history of loss of consciousness (LOC)
- Headache, seizures, dizziness, memory problems
- Gait/balance problems, nausea, vomiting, difficulty concentrating
- Visual Disturbances, tinnitus, slurred speech
- Disoriented, irritable, confused
- Extremity weakness or numbness

#### Pediatric considerations:
- Traumatic brain injury (TBI) can occur in patients who have not had a loss in consciousness. Children may appear alert and awake initially but should be evaluated if they have any of the following symptoms:
  - Abnormal behavior (i.e. irritability, excessive sleepiness)
  - Persistent vomiting
  - Seizures
  - Loss of consciousness
  - Evidence of CSF leak

- Young children have immature neck musculature and relatively large heads which makes them more prone to cervical spine injuries in C1-C3.
- Children less than 8 years old are

### Glasgow Coma Scale (GCS)/ Pediatric Glasgow Coma Scale (PGCS)

- **Mild TBI**: At least 1 of the following inclusion criteria present:
  - Any period of LOC of < 30 minutes and GCS/PGCS of 13-15 after the LOC
  - Any loss of memory of the event immediately before or after the incident with posttraumatic amnesia of < 24hrs
  - Any alteration in mental status at the time of incident

- **Moderate to Severe TBI**: GCS/PGCS < 12

- CT scan for hemorrhage, cerebral contusion, fracture, foreign bodies
- Cervical spine imaging for all patients with head injury
- MRI is more sensitive to diagnosis diffuse axonal injury

### Record initial GCS/PGCS and reassess per protocols
- Re-evaluate patient every 24 hours or sooner if symptoms worsen
- Maintain:
  - Cerebral perfusion pressure
  - Body temperature
  - Neuromuscular blockage and sedation (for intubated patients)
  - Cervical spine control
  - Glucose control
  - Seizure control
  - DVT prophylaxis

- Complete rest until asymptomatic
- Symptoms that persist beyond 7-10 days suggests post-concussion syndrome and warrants additional follow up.
<table>
<thead>
<tr>
<th>Crush Injury and Crush Syndrome</th>
<th>Crush Injury and Crush Syndrome</th>
<th>Crush Injury and Crush Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>susceptible to SCIWORA (spinal cord injury without radiographic abnormality)</td>
<td>• Consider cervical spine injury in children with head injury</td>
<td>• If possible, administer IVF before releasing crushed body part</td>
</tr>
<tr>
<td>• Consider cervical spine injury in children with head injury</td>
<td>• Reperfusion syndrome:</td>
<td>• Administer IV hydration</td>
</tr>
<tr>
<td></td>
<td>o Hypotension</td>
<td>o Maintain urine output of 2-4mL/kg/hr</td>
</tr>
<tr>
<td></td>
<td>o Renal failure d/t rhabdomyolysis, myoglobinuria and metabolic abnormalities</td>
<td>o Monitor for cardiac arrhythmias</td>
</tr>
<tr>
<td></td>
<td>o Metabolic abnormalities (hypocalcemia, hyperkalemia, metabolic acidosis)</td>
<td>• Treat hyperkalemia and hypocalcemia</td>
</tr>
<tr>
<td></td>
<td>o Cardiac arrhythmias</td>
<td>• Alkalize the urine</td>
</tr>
<tr>
<td></td>
<td>o Compartment syndrome</td>
<td>• Monitor for renal failure-consider hemodialysis as needed</td>
</tr>
<tr>
<td></td>
<td>• History of events/ injury</td>
<td>• Monitor for compartment syndrome</td>
</tr>
<tr>
<td></td>
<td>• Laboratory tests</td>
<td>• Monitor urine for red blood cells</td>
</tr>
<tr>
<td>Ear Injury</td>
<td>• External Ear: may have degloving of cartilage which is considered a serious injury</td>
<td>• Treat open wounds with antibiotics and tetanus vaccination</td>
</tr>
<tr>
<td></td>
<td>• Tympanic Membrane (TM):</td>
<td>• Observe all crush injuries and monitor for the pain, pallor, paresthesia, pain with passive movement and pulselessness</td>
</tr>
<tr>
<td></td>
<td>o Can be stretched and displaced medially</td>
<td>• External Ear:</td>
</tr>
<tr>
<td></td>
<td>o Range of injuries includes intra-tympanic hemorrhage to TM perforation</td>
<td>o Manage injuries with foreign body removal, clean and close wounds</td>
</tr>
<tr>
<td></td>
<td>o Injuries can be unilateral or bilateral, small or complete, single or double</td>
<td>o Consider consultation on closure requirements if cartilage of pinna is degloved</td>
</tr>
<tr>
<td></td>
<td>o Laceration can be smooth and linear, punched out or ragged with inverted or everted edges</td>
<td>• Tympanic Membrane:</td>
</tr>
<tr>
<td></td>
<td>• Middle Ear:</td>
<td>o Rupture: Keep ear clean and dry. Refer patient to specialist</td>
</tr>
<tr>
<td></td>
<td>o Conductive and sensorineural hearing</td>
<td>o Perforation: Antibiotic eardrops to irrigate and clear ear of debris</td>
</tr>
<tr>
<td></td>
<td>• Otoscopic evaluation</td>
<td>• Middle and Inner Ear:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Can defer until patient can see specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Will need audiometry exams</td>
</tr>
<tr>
<td>Extremity Injuries</td>
<td>Eye Injuries</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------</td>
<td></td>
</tr>
</tbody>
</table>
| - Traumatic amputations: primarily occur through bony shaft rather than joint disarticulations  
- Fragments imbedded into extremity  
- Blunt force injuries  
- Crush injuries (see above for more information) | - Presents with wide range of symptoms  
- Significant eye damage may be present with normal vision and minimal symptoms (irritation, foreign body sensation, altered vision, bleeding, periorbital swelling or bruising)  
- Minor injuries include: Corneal abrasions, conjunctivitis, superficial foreign bodies  
- Open globe (360° conjunctival hemorrhage, misshapen pupil, brown/pigmented tissue outside of globe, clear gel like tissue outside of globe, abnormally deep or shallow anterior chamber  
- Eyelid lacerations are common  
- Serious non-penetrating injuries: hyphema, traumatic cataract, citrous hemorrhage, retinal detachment, |
| - Document systemic musculoskeletal, neurological, and vascular states of each extremity  
- Document each open wound  
- Photograph if possible  
- Radiological exams as indicated | - Obtain visual acuity  
- Test for light perception, hand motion and count fingers  
- Thin cut CT scan of orbits may help identify foreign bodies  
- MRI is contraindicated until proven that no metal foreign bodies are present |
| - Perform thorough debridement  
- Antibiotics for all open fractures  
- Obviously contaminated wounds:  
  - Irrigate with sterile saline; dress with Betadine soaked sponges  
- Tetanus prophylaxis if indicated  
- Splint fractured extremities  
- Surgical management:  
  - Initial debridement and bony stabilization should be done in OR | - Do not force eyelid open-defer exam if massive swelling is present  
- Assume all eye injures may also be ruptured globe  
- Do not patch or bandage the eye  
- Use convex plastic or metal shield or the bottom of a clean paper/Styrofoam cup taped in place  
- Do not remove impaled FBs  
- Tetanus if indicated  
- Administer anti-emetics for nausea and vomiting  
- Administer IV broad spectrum antibiotics if rupture globe is suspected  
- Consult an ophthalmologist as soon as possible  
- Rapid transport to facility with ophthalmic OR capabilities is primary goal |
<table>
<thead>
<tr>
<th>Lung/Chest Injury</th>
<th>Choroidal rupture and optic nerve injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>• May present with no external injuries to chest</td>
<td>• Chest radiography: characteristic “butterfly” pattern</td>
</tr>
<tr>
<td>• Symptoms: dyspnea, hemoptysis, cough, chest pain</td>
<td>• Arterial blood gases (ABG)</td>
</tr>
<tr>
<td>• Signs: tachypnea, hypoxia, cyanosis, apnea, wheezing, decreased breath sounds, hemodynamic instability</td>
<td>• CT Chest</td>
</tr>
<tr>
<td>• Associated pathology: bronchopleural fistula, air emboli, hemothorax, pneumothorax</td>
<td>• Doppler</td>
</tr>
<tr>
<td><strong>Pediatric Considerations:</strong></td>
<td><strong>Care is similar to a pulmonary contusion</strong></td>
</tr>
<tr>
<td>o Chest injuries are a common cause of death in children after an explosive event. Below are some anatomical features found in children that affect their injury pattern:</td>
<td>o Cautious IVF use ensuring tissue perfusion without volume overload</td>
</tr>
<tr>
<td>o Chest wall is more compliant so rib fractures are less common. Severe thoracic injuries can occur without significant external evidence of injury</td>
<td>o High flow oxygen to prevent hypoxemia</td>
</tr>
<tr>
<td>o Mediastinal structures are more mobile. Tension pneumothorax can shift mediastinum and cause respiratory and cardiovascular compromise. Suspect tension pneumothorax in children who are hypotensive and hypoxic</td>
<td>o Secure airway for: impending airway compromise, secondary edema, injury or massive hemoptysis</td>
</tr>
<tr>
<td>o Traumatic asphyxia results from sudden compression of the abdomen or chest against a closed glottis. Symptoms include: hyperemic sclera, seizures, disorientation, petechiae on upper body, respiratory failure. Treatment is supportive.</td>
<td>o Prompt decompression for hemo or Pneumo thorax</td>
</tr>
<tr>
<td></td>
<td>o Use caution with decision to intubate patient-mechanical ventilation and positive end pressure may increase risk of alveolar rupture and air embolism</td>
</tr>
<tr>
<td></td>
<td>o Air embolism: high flow oxygen; place patient in prone, semi-left lateral or left lateral position and transfer to hyperbaric chamber</td>
</tr>
<tr>
<td></td>
<td>o Patients with normal chest xray and ABG and no complaints can be discharged after observing for 4-6 hours</td>
</tr>
<tr>
<td>Mental health</td>
<td>Will vary based on age and developmental level</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Purpose: To provide guidance to practitioners caring for pediatric patients who need inpatient hospital care during a disaster.

Disclaimer: This guideline is not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the healthcare provider.

Sample Pediatric Standard Admission Orders
Sample Pediatric Respiratory Admission Orders
Sample Pediatric Septic Shock Admission Orders
Sample Pediatric Hypovolemic Shock Admission Orders
Sample Pediatric Trauma/Blast Injury Admission Orders
Sample Pediatric Standard Admission Orders

Admitting physician: _____________________________________________________________

Diagnosis: _____________________________________________________________________

Condition: □ Critical □ Serious □ Stable

Patient Admission Status: □ Full inpatient □ Observation □

Weight (kg): ____________________ Height (cm): __________________

Allergies: _____________________________________________________________________

Activity:
□ As tolerated
□ Strict bed rest
□ Bed rest with bathroom privileges

Isolation: _____________________________________________________________________

Vital signs/assessment:
□ Per nursing protocol (if applicable)
□ Continuous cardiac monitoring
□ Continuous pulse-ox
□ Spot check pulse-ox with vitals and if exhibiting respiratory difficulty
□ Continuous pulse-ox if patient receiving supplemental O2
□ Routine I & O
□ Strict I & O
□ Daily weights
□ BP with vitals
□ Seizure precautions
□ Neuro checks every ______
□ Notify physician if temperature is greater than ____ or less than ____
□ Notify physician if pulse oximetry is less than _____
□ Other _______________________________________________________________________

Diet:
□ General PO ad lib
□ Soft diet PO ad lib
□ Full liquid diet PO ad lib
□ Clear liquid diet PO ad lib
□ Breastfeeding PO ad lib
□ ____________________________ formula PO ad lib
□ NPO
□ Other _______________________________________________________________________

IVS:
□ Saline Lock
□ NS bolus ______ mL IV to run over 1 – 2 hours
□ D5 ½ NS with 20 mEq KCl/L to run at ________mL/hr
□ D5 ¼ NS with 20 mEq KCl/L to run at ________mL/hr
Sample Pediatric Admission Orders

Supplemental Oxygen:
Oxygen to maintain saturation ≥__________% via:
☐ Nasal cannula ________________
☐ High-humidity nasal cannula ________________
☐ High flow high humidity nasal cannula ______ L
☐ Trach collar ________________
☐ Other: ____________________________

Respiratory Treatments:
☐ ________________________________
☐ ________________________________
☐ ________________________________

Labs:
☐ CBC with Differential
☐ CBC (Hemogram)
☐ CMP
☐ BMP
☐ CBG
☐ VBG
☐ ESR
☐ CRP
☐ UA: ☐ Clean catch ☐ Bagged ☐ Cath ☐ HCG ☐ Urine culture
☐ Blood culture
☐ Stool for: ☐ Culture ☐ Rotavirus ☐ C. diff ☐ O&P ☐ Gram stain
☐ Heme
☐ NP wash for: ☐ RSV ☐ Influenza ☐ Viral culture
☐ ________________________________
☐ ________________________________
☐ ________________________________
☐ ________________________________
☐ ________________________________

Radiology:
☐ CXR (AP) Reason: ________________________________
☐ CXR (PA and lateral) Reason: ________________________________
☐ Abdominal series Reason: ________________________________
☐ KUB Reason: ________________________________
☐ Other ________________________________
☐ Other ________________________________
☐ Other ________________________________
Medications:

☐ Fever/pain control:
  - Acetaminophen (Tylenol) (15 mg/kg/dose) ______ mg PO/GT every 4 hours PRN temperature ≥ than 101.5ºF and/or discomfort (not to exceed 4000 mg a day)
  - Acetaminophen (Tylenol) (20 mg/kg/dose) ______ mg PR every 4 hours PRN temperature ≥ 101.5ºF and/or discomfort (not to exceed 4000 mg a day)
  - Ibuprofen (Motrin) (10 mg/kg/dose) ______ mg PO/GT every 6 hours PRN temperature 101.5ºF and/or discomfort
  - Morphine (0.1-0.2 mg/kg) _____ mg IV every 2-4 hours as needed (max 10mg/dose)
  - Fentanyl ______ mcg IV every ______ hours as needed.

☐ Topical Anesthetic to be applied prior to routine blood draws and IV starts

☐ Other:

☐ ______________________________________________________________________

☐ ______________________________________________________________________

☐ ______________________________________________________________________

☐ ______________________________________________________________________

Consults:

☐ ______________________________________________________________________

☐ ______________________________________________________________________

☐ ______________________________________________________________________

Additional Orders:

☐ ______________________________________________________________________

☐ ______________________________________________________________________

☐ ______________________________________________________________________

☐ ______________________________________________________________________
Sample Pediatric Respiratory Admission Orders

Admitting physician: ___________________________________________________________
Diagnosis: __________________________________________________________________
Condition: □ Critical □ Serious □ Stable
Weight (kg): ____________________ Height (cm): ____________________
Allergies: __________________________________________ _______________________

Pulse Oximetry:
- Obtain pulse oximetry on admission to unit
- If SpO₂ > 90%, obtain spot check pulse oximetry readings with each treatment, with vital signs or if patient exhibits decline in respiratory status
- If SpO₂ < 90%, provide oxygen and begin continuous pulse oximetry monitoring

Supplemental Oxygen Orders:
- If SpO₂ < 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain pulse oximetry >90%
- Wean oxygen if oxygen saturation maintains 94%.
  - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

□ Ventilator settings: ________________________________________________________
  - For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

Peak Expiratory Flow Rate (PEFR)
- Peak Flow will be done on admission for patients > 5 years of age to determine patient’s compliance/ability to effectively perform
- Check Peak Flow before and after breathing treatments.

AVERAGE PREDICTED PEAK EXPIRATORY FLOW RATES FOR NORMAL CHILDREN

<table>
<thead>
<tr>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
<th>Height</th>
<th>PEFR (L/min)</th>
<th>70% PEFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>In</td>
<td>Cm</td>
<td></td>
<td>In</td>
<td>Cm</td>
<td></td>
<td>In</td>
<td>Cm</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>109</td>
<td>147</td>
<td>103</td>
<td>52</td>
<td>132</td>
<td>267</td>
<td>187</td>
<td>60</td>
</tr>
<tr>
<td>44</td>
<td>112</td>
<td>160</td>
<td>112</td>
<td>53</td>
<td>135</td>
<td>280</td>
<td>196</td>
<td>61</td>
</tr>
<tr>
<td>45</td>
<td>114</td>
<td>173</td>
<td>121</td>
<td>54</td>
<td>137</td>
<td>293</td>
<td>205</td>
<td>62</td>
</tr>
<tr>
<td>46</td>
<td>117</td>
<td>187</td>
<td>131</td>
<td>55</td>
<td>140</td>
<td>307</td>
<td>215</td>
<td>63</td>
</tr>
<tr>
<td>47</td>
<td>119</td>
<td>200</td>
<td>140</td>
<td>56</td>
<td>142</td>
<td>320</td>
<td>224</td>
<td>64</td>
</tr>
<tr>
<td>48</td>
<td>122</td>
<td>214</td>
<td>150</td>
<td>57</td>
<td>145</td>
<td>334</td>
<td>234</td>
<td>65</td>
</tr>
<tr>
<td>49</td>
<td>124</td>
<td>227</td>
<td>159</td>
<td>58</td>
<td>147</td>
<td>347</td>
<td>243</td>
<td>66</td>
</tr>
<tr>
<td>50</td>
<td>127</td>
<td>240</td>
<td>168</td>
<td>59</td>
<td>150</td>
<td>360</td>
<td>252</td>
<td>67</td>
</tr>
</tbody>
</table>

Illinois EMSC  www.luhs.org/emsc
### Medications:

- **Albuterol**
  - MDI via spacer device
    - 2 puffs every 3 hours (6-11 months old)
    - 4 puffs every 3 hours (>12 months old)
  - Nebulizer _______mg every ____ hrs (0.5mg/kg/hr, max dose 30mg/hr)
  - Continuous
    - If patient requires treatment prior to two hour interval, administer Albuterol
      continuous nebulizer for two hours and begin continuous pulse oximetry monitoring
      - Albuterol 0.5mg/kg/hr (max dose 10mg/hr)
- **Ipratropium bromide (Atrovent):**
  - 0.5mg to be given with 2\textsuperscript{nd} and 3\textsuperscript{rd} doses of Albuterol
- **Corticosteroids:**
  - Prednisolone Sodium Phosphate (Orapred): _____mg PO STAT (2mg/kg loading dose-max 60mg/dose) then _____mg PO every 12 hours (1mg/kg maintenance dose-max 30mg/dose) x 5 days
  - Methylprednisone (Solumedrol): _____mg IV STAT (2mg/kg loading dose-max 60mg/dose) then _____mg IV every 6 hours (1mg/kg maintenance dose-max 30mg/dose) x 4 doses
- **Topical anesthetic for IV start and lab draws:**
  - Apply topically once 30-90 minutes prior to painful procedures (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)
- **Antibiotics:**
  - 
  - 
  - 
- **Fever/Pain Control**
  - Acetaminophen (Tylenol) (15mg/kg/dose) _____mg PO/GT every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  - Acetaminophen (Tylenol) (20mg/kg/dose) _____mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  - Ibuprofen (Motrin) (10mg/kg/dose) _____mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort

- See **Sample Pediatric Standard Admission Orders** for additional examples for diet, IV, labs etc.
- Asthma Score (see below)
Sample Pediatric Septic Shock Admission Orders

Admitting physician: ____________________________________________

Diagnosis: ______________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg): ___________ Height (cm): ____________

Allergies: _______________________________________________________

Isolation: _______________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O
□ Daily weight
□ Seizure precautions
□ Neuro checks ever _____ hours
□ All non-rectal temperatures > 38°C/100.4°F should be confirmed rectally on infants ≤60 days of age

Tests:
□ CBC with differential
  □ now (order if not performed prior to admission)
  □ at ______
  □ every _____ hours
□ CMP
  □ now (order if not performed prior to admission)
  □ at ______
  □ every _____ hours
□ BMP
  □ now (order if not performed prior to admission)
  □ at ______
  □ every _____ hours
□ Blood culture (order if not performed prior to admission)
□ Viral blood culture
□ Catheterized urinalysis (order if not performed prior to admission)
□ Catheterized urine culture (order if not performed prior to admission)
□ Stool culture
□ Stool for Rotavirus
□ Stool gram stain
□ RSV
□ Influenza
□ Viral culture
□ Chest x-ray (PA and lateral) (order if not performed prior to admission)

For infants ≤60 days of age with fever:
☐ CSF for (laboratory should perform these in ranking order as listed below)
  ☐ Cell count
  ☐ Glucose
  ☐ Protein
  ☐ Gram stain
  ☐ Aerobic culture
  ☐ Viral culture
  ☐ Enterovirus PCR
  ☐ Herpes PCR
  ☐ Meningitis antigen profile
☐ Conjunctiva viral culture
☐ Viral culture of skin lesion on __________________
☐ Rectal viral culture

Medications:
☐ Fever/Pain Control:
  ☐ Acetaminophen (Tylenol) (15mg/kg/dose) ________mg PO/GT every 4 hrs PRN for
temperature 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Acetaminophen (Tylenol) (20mg/kg/dose) ________mg PR every 4 hrs PRN for temperature ≥
38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  ☐ Ibuprofen (Motrin) (10mg/kg/dose) ________mg PO/GT every 6 hours PRN for temperature
≥ 38.6°C/101.5°F or discomfort (for infants >5 months)
☐ Antibiotics:
  ☐ Ceftriaxone ______ mg IV every ______ hours (max 4gm/day)
  ☐ Vancomycin ______mg IV every ______ hours (max 1gm/dose)
  ☐ ______________________________
  ☐ ______________________________
  ☐ ______________________________
  ☐ ______________________________
☐ For infants ≤60 days of age with fever:
  ☐ Ampicillin ________ mg IV every 6 hours (200 mg/kg/day)
  ☐ Cefuroxime ________mg IV every 6 hours (200 mg/kg/day)
  ☐ Acyclovir ________mg IV every ______ hours
  (If greater than or equal to 35 weeks post-conceptual age, give 60 mg/kg/day divided
every 8 hours. If less than 35 weeks post conceptual age, give 40 mg/kg/day divided
every 12 hours)
  ☐ Gentamycin ________mg IV every ______hours
☐ Topical anesthetic for IV start and lab draws:
  ☐ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area
squared, or application time of 2 hours)

IV Therapy:
☐ Saline lock
☐ D5 ½ NS with 20 mEq KCl/L running at ______ mL/hr (ensure patient is voiding)
Sample Pediatric Admission Orders

☐ ______________________ running at _____ mL/hr
☐ ______________________ running at _____ mL/hr

Supplemental Oxygen Orders:
- If SpO₂ < 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain SpO₂ > 90%
- Wean oxygen if oxygen saturation maintains 94%.
  - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

☐ Ventilator Settings:_____________________________________________________
- For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

☐ See Sample Pediatric Standard Admission Orders for additional examples for diet, IV, labs etc
Sample Pediatric Hypovolemic Shock Admission Orders

Admitting physician: ____________________________________________________________

Diagnosis: ____________________________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg): __________________ Height (cm): ______________________

Allergies: _____________________________________________________________________

Isolation: ____________________________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O
□ Daily weight

Tests:
□ CBC with differential
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours

□ CMP
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours

□ BMP
   □ now (order if not performed prior to admission)
   □ at ______
   □ every ______ hours

Medications:
□ Fever/Pain Control:
   □ Acetaminophen (Tylenol) (15mg/kg/dose) _________mg PO/GT every 4 hrs PRN for temperature ≥38.6°C/101.5°F or discomfort (max dose 3000mg/day)
   □ Acetaminophen (Tylenol) (20mg/kg/dose) _________mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
   □ Ibuprofen (Motrin) (10mg/kg/dose) _________mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort (for infants >5 months)

□ Antiemetic:
   □ _______________________________________________________________________
   □ _______________________________________________________________________

□ Antibiotics:
   □ _______________________________________________________________________
   □ _______________________________________________________________________
   □ _______________________________________________________________________
☐ Topical anesthetic for IV start and lab draws:
  ☐ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)

**IV Therapy:**

☐

☐ D5 ½ NS with 20 mEq KCl/L running at _____ mL/hr (ensure patient is voiding)
☐ __________________ running at _____ mL/hr
☐ __________________ running at _____ mL/hr

**Supplemental Oxygen Orders:**

- If SpO₂< 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  - Nasal Cannula
  - Aerosol Mask
- Titrate oxygen to maintain SpO₂>90%
- Wean oxygen if oxygen saturation maintains 94%.
  - Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - Do not decrease oxygen more frequently than every 60 minutes

☐ Ventilator Settings:________________________________________________________________

- For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

☐ See **Sample Pediatric Standard Admission Orders** for additional examples for diet, IV, labs etc
Sample Pediatric Trauma/Blast Injury Admission Orders

Admitting physician: _____________________________________________

Diagnosis: ____________________________________________________

Condition:  □ Critical  □ Serious  □ Stable

Weight (kg): ____________________  Height (cm): ___________________

Allergies: ____________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O q 1 hour (maintain urine output at 2-4mL/kg/hr)
□ Daily weight
□ Seizure precautions
□ Neuro checks ever _____ hours
□ Perform CMS checks on extremities every ____ hours to monitor for compartment syndrome/crush syndrome

Tests:
□ __________________________________________________________
□ __________________________________________________________
□ __________________________________________________________

Medications:
□ Fever/Pain Control:
  □ Acetaminophen (Tylenol) (15mg/kg/dose) ______ mg PO/GT every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Acetaminophen (Tylenol) (20mg/kg/dose) ______ mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Ibuprofen (Motrin) (10mg/kg/dose) ________ mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort (for infants >5 months). Ensure adequate renal function before utilizing.
  □ Morphine (0.1-0.2 mg/kg) _____ mg IV every 2-4 hours as needed (max 10mg/dose)
  □ Fentanyl ______ mcg IV every _____ hours as needed.

□ Antibiotics:
□ __________________________________________________________
□ __________________________________________________________
□ __________________________________________________________

□ Topical anesthetic for IV start and lab draws
  □ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)
**IV Therapy:**
- □ Saline Lock
- □ NS bolus ______ mL IV to run over 1–2 hours
- □ LR bolus ______ mL IV to run over 1-2 hours
- □ D5 ½ NS with 20 mEq KCl/L to run at _________ mL/hr (Ensure adequate renal function before utilizing potassium)
- □ D5 ¼ NS with 20 mEq KCl/L to run at _________ mL/hr (Ensure adequate renal function before utilizing potassium)
- □ Other________________________________________________________

**Supplemental Oxygen Orders:**
- • If SpO₂ < 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  - o Nasal Cannula
  - o Aerosol Mask
- • Titrate oxygen to maintain SpO₂ > 90%
- • Wean oxygen if SpO₂ maintains 94%.
  - o Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  - o Do not decrease oxygen more frequently than every 60 minutes

**Ventilator Settings:**
- o For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

**See Sample Pediatric Standard Admission Orders** for additional orders for diet, IV, labs etc
- □ If hypovolemic, refer to Pediatric Shock Care Guidelines: Sample Hypovolemic Shock Admission Orders
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>ABC</td>
<td>Airway, breathing, circulation</td>
</tr>
<tr>
<td>ABG</td>
<td>Arterial blood gas</td>
</tr>
<tr>
<td>ABO &amp; Rh</td>
<td>Blood group antigens (ABO) and the Rh antigen</td>
</tr>
<tr>
<td>APGAR</td>
<td>Appearance, Pulse, Reflex (Grimace), Activity, Respirations</td>
</tr>
<tr>
<td>ATLS</td>
<td>Advance Trauma Life Support course</td>
</tr>
<tr>
<td>BE</td>
<td>Base excess</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>BPM</td>
<td>Beats per minute</td>
</tr>
<tr>
<td>BVM</td>
<td>Bag valve mask</td>
</tr>
<tr>
<td>CBC</td>
<td>Complete blood count</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
</tr>
<tr>
<td>CK-MB</td>
<td>Creatine kinase MB</td>
</tr>
<tr>
<td>CMP</td>
<td>Complete metabolic panel</td>
</tr>
<tr>
<td>C-Spine</td>
<td>Cervical spine</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
</tr>
<tr>
<td>cm</td>
<td>centimeter</td>
</tr>
<tr>
<td>CMS</td>
<td>Circulation/color, movement, sensation</td>
</tr>
<tr>
<td>CNS</td>
<td>Central nervous system</td>
</tr>
<tr>
<td>CO</td>
<td>Carbon monoxide</td>
</tr>
<tr>
<td>CT</td>
<td>Cat scan</td>
</tr>
<tr>
<td>CXR</td>
<td>Chest x-ray</td>
</tr>
<tr>
<td>DBP</td>
<td>Diastolic blood pressure</td>
</tr>
<tr>
<td>dL</td>
<td>Deciliter</td>
</tr>
<tr>
<td>d/t</td>
<td>Due to</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep vein thrombosis</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EMSC</td>
<td>Emergency Medical Services for Children</td>
</tr>
</tbody>
</table>

**2015**

**IDPH ESF-9 Plan: Pediatric and Neonatal Surge Annex**

**Pediatric Care Guideline Acronym List**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESF-8</td>
<td>Emergency Support Function # 8</td>
</tr>
<tr>
<td>EtCO_2</td>
<td>End title CO_2</td>
</tr>
<tr>
<td>FAST</td>
<td>Focused Abdominal Sonography for Trauma exam</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FiO_2</td>
<td>Fracture of inspired oxygen</td>
</tr>
<tr>
<td>G6PD</td>
<td>Glucose-6-phosphate dehydrogenase deficiency</td>
</tr>
<tr>
<td>GCS</td>
<td>Glasgow Coma Scale</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>gm</td>
<td>Gram</td>
</tr>
<tr>
<td>GT</td>
<td>Gastric tube</td>
</tr>
<tr>
<td>Gy</td>
<td>Unit of absorbed dose, specific energy (imparted) and of kerma</td>
</tr>
<tr>
<td>H_2O^+</td>
<td>Water</td>
</tr>
<tr>
<td>Hgb</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HOB</td>
<td>Head of bed</td>
</tr>
<tr>
<td>HR</td>
<td>Heart Rate</td>
</tr>
<tr>
<td>hr</td>
<td>Hour</td>
</tr>
<tr>
<td>I-time</td>
<td>Inspiratory time</td>
</tr>
<tr>
<td>I &amp; O</td>
<td>Intake and output</td>
</tr>
<tr>
<td>IDPH</td>
<td>Illinois Department of Public Health</td>
</tr>
<tr>
<td>IEMA</td>
<td>Illinois Emergency Management Agency</td>
</tr>
<tr>
<td>IILI</td>
<td>Influenza like illness</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IN</td>
<td>Intranasal</td>
</tr>
<tr>
<td>IO</td>
<td>Intraosseous</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>IVF</td>
<td>Intravenous fluids</td>
</tr>
<tr>
<td>K</td>
<td>Potassium</td>
</tr>
<tr>
<td>k-cal</td>
<td>Kilocalorie</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>KCl</td>
<td>Potassium Chloride</td>
</tr>
<tr>
<td>KI</td>
<td>Potassium Iodide</td>
</tr>
<tr>
<td>kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>L</td>
<td>liter</td>
</tr>
<tr>
<td>LOC</td>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>LPM</td>
<td>Liter per minute</td>
</tr>
<tr>
<td>LR</td>
<td>Lactated Ringers</td>
</tr>
<tr>
<td>mcg</td>
<td>microgram</td>
</tr>
<tr>
<td>MDI</td>
<td>meter dose inhaler</td>
</tr>
<tr>
<td>mEq</td>
<td>milliequivalent</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
</tr>
<tr>
<td>min</td>
<td>Minute</td>
</tr>
<tr>
<td>mL</td>
<td>Milliliter</td>
</tr>
<tr>
<td>mmHG</td>
<td>millimeter of mercury</td>
</tr>
<tr>
<td>mos</td>
<td>month</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>NC</td>
<td>Nasal cannula</td>
</tr>
<tr>
<td>NG</td>
<td>Nasogastric</td>
</tr>
<tr>
<td>NPO</td>
<td>Nothing by mouth</td>
</tr>
<tr>
<td>NRB</td>
<td>Non-rebreather mask</td>
</tr>
<tr>
<td>NRP</td>
<td>Neonatal Resuscitation Provider Course</td>
</tr>
<tr>
<td>NS</td>
<td>Normal saline</td>
</tr>
<tr>
<td>O₂</td>
<td>Oxygen</td>
</tr>
<tr>
<td>OOB</td>
<td>Out of bed</td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
</tr>
<tr>
<td>PALS</td>
<td>Pediatric Advanced Life Support Course</td>
</tr>
<tr>
<td>PaO₂</td>
<td>Partial pressure of oxygen in blood</td>
</tr>
<tr>
<td>PASG</td>
<td>Pneumatic antishock garment</td>
</tr>
<tr>
<td>PCO₂</td>
<td>Partial pressure of carbon dioxide in blood</td>
</tr>
<tr>
<td>PEEP</td>
<td>Positive End Expiratory Pressure</td>
</tr>
<tr>
<td>PFA</td>
<td>Psychological first aid</td>
</tr>
<tr>
<td>pg</td>
<td>page</td>
</tr>
<tr>
<td>PGCS</td>
<td>Pediatric Glasgow Coma Scale</td>
</tr>
<tr>
<td>PO</td>
<td>By mouth</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
</tr>
<tr>
<td>PPV</td>
<td>Positive Pressure Ventilation</td>
</tr>
<tr>
<td>PR</td>
<td>Per rectum</td>
</tr>
<tr>
<td>PRN</td>
<td>As needed</td>
</tr>
<tr>
<td>PT/PTT</td>
<td>Prothrombin time/ Partial Thromboplastic time</td>
</tr>
<tr>
<td>PTS</td>
<td>Pediatric Trauma Score</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RAD</td>
<td>Radiation absorbed dose</td>
</tr>
<tr>
<td>REAC/TS</td>
<td>Radiation Emergency Assistance Center/Training Site</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cells</td>
</tr>
<tr>
<td>RR</td>
<td>Respiration rate</td>
</tr>
<tr>
<td>RT</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>SBP</td>
<td>Systolic blood pressure</td>
</tr>
<tr>
<td>SCIWORA</td>
<td>Spinal cord injury without radiographic abnormality</td>
</tr>
<tr>
<td>SGA</td>
<td>Small for gestational age</td>
</tr>
<tr>
<td>SNS</td>
<td>Strategic National Stockpile</td>
</tr>
<tr>
<td>SpO₂</td>
<td>Blood oxygen saturation</td>
</tr>
<tr>
<td>SQ</td>
<td>Subcutaneous</td>
</tr>
<tr>
<td>STABLE</td>
<td>Sugar &amp; Safe Care, Temperature, Airway, Blood Pressure, Lab Work, Emotional Support Course</td>
</tr>
<tr>
<td>T1-T3</td>
<td>Thoracic spine 1-Thoracic spine 3</td>
</tr>
<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>TBSA</td>
<td>Total body surface area</td>
</tr>
<tr>
<td>TID</td>
<td>Three times per day</td>
</tr>
<tr>
<td>TM</td>
<td>Tympanic membrane</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid stimulating hormone</td>
</tr>
<tr>
<td>y/o</td>
<td>year old</td>
</tr>
<tr>
<td>°C</td>
<td>Degree Celsius</td>
</tr>
<tr>
<td>°F</td>
<td>Degree Fahrenheit</td>
</tr>
</tbody>
</table>
Burn Care Guideline:


Inpatient Treatment and Monitoring Interventions

- Agency for Healthcare Research & Quality (AHRQ).
- Rockford Health System. (2012). Pediatric unit admission orders. Used with permission

Newborn Care


Premature Newborn

- Consultation of this document provided by personal communication with Dr. Frank Hernandez, Neonatologist, Rockford Memorial Hospital, Rockford, IL
- Hypothermia Task Force. Led by Dr Patricia Ittmann, Neonatologist. Rockford Memorial Hospital. Rockford, IL

Radiation

IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex
Pediatric and Neonatal Care Guidelines Reference List

2015


Respiratory
- American Heart Association (AHA). (2011). Pediatric advanced life support
- Cincinnati Children’s Hospital Medical Center. (2002). Asthma score/respiratory assessment/care record.

Shock Care Guideline
- American Heart Association (AHA). (2011). Pediatric advanced life support

Rockford Health System. (2011). Pediatrics - infants 60 days or less with fever. Used with permission.

Trauma & Blast Injury Care Guideline