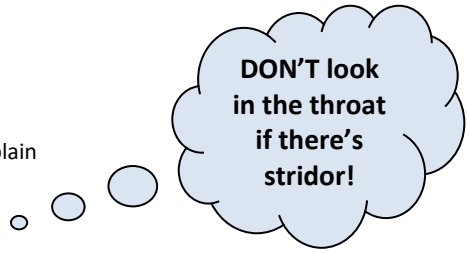
3 Minute General Child Assessment

Do this for every child followed by (or incorporated with) an in depth relevant system examination



Intro

- **W**ash hands, **I**ntroduce self, ask **P**atients name & DOB & what they like to be called, **E**xplain examination and get consent

Airway

- Listen: stridor (croup, foreign body), secretions

Breathing

- Inspect:
  - Respiratory rate (increased in respiratory distress, septicaemia, ketoacidosis...)
  - Recession (subcostal, intercostal, sternal), nasal flaring, tracheal tug, accessory muscle use
- Oxygen saturation (>97 normal, <94 significant illness, <90 alarming)
- Auscultation: if child is crying, try and listen to inspirations. Noises transmit all over the chest because they are small (wheezing in asthma, crepitations in bronchiolitis, bronchial breathing) *Do back after doing everything on front!

Circulation

- Colour: pallor, mottled arms/legs, blue (poor perfusion; few mottle quite frequently)
- Radial pulse rate (brachial if <6 months)
- Hydration signs:
  a. Wet nappies
  b. Mucous membranes
  c. Skin turgur
  d. Capillary refill central and peripheral. Press for 5s, <2s to return is normal and check temperature of hands and feet compared with trunk (will be cooler in peripheral vasoconstriction in sepsis or dehydration)
- Auscultate heart sounds
- Blood pressure if very unwell (maintained until late in shock)

Disability (Neuro)

- Alertness & activity:
  - Note how alert & reactive to surroundings (drowsy after fit or fever)
  - Look at behaviour (true irritability (i.e. can't be consoled) = raised ICP or meningitis)
  - AVPU score/ GCS
  - Fontanelle (bulging = raised ICP)
- Pupils with torch if very unwell (sluggish response = post-ictal or drug overdose, changing sizes = seizure, asymmetrical = SOL e.g. sub/extradural, abnormal gaze may happen after seizure)
- Limb tone and movement, joint swelling
- RASH!!!! Look all over!
- Capillary glucose measurement if decreased alertness

NORMAL	<1 year	1-2 years	2-5 years	5-12 years	>12 years
Resp rate	30-40	25-35	25-30	20-25	15-20
Heart rate	110-160	100-150	95-140	80-120	60-100

Everything else

ENT

Give clear instructions to mum…

- Ears: child must be stable. Sit child sideways on mums lap and stress child must be held tight. Mum holds one hand on babys head and other over their body. Use your free hand to hold the head in against mum's chest. Eardrums often pink.
- Throat: position the child facing you. One of mums arms across both of child's arms and the other holding forehead back. May need to prize open with tongue depressor. Children often have large red tonsils.

Temperature

- Measure with tympanic themometer or tempadot strip in mouth or axilla (axilla recommended in babies)

Tummy

- Feel: best laying flat but may have to make do on mums lap. Ask where pain is. Palpate gently first then deeper. Check for hepatosplenomegaly as in adult.

	Amber flags	Red flags
A		Stridor
B	Nasal flaring, tachypnoea, sats <95%	Respiratory distress (RR>60)
C	Pallor, tachycardia, reduced capillary refill, reduced UO, dry mucus membranes	Pale/mottled/blue, reduced skin turgor
D	Reduced activity, not responding normally to social cues	Unresponsive/won't stay awake, non-blanching rash/neck stiffness, seizures
E	Rigors, fever in 3-6month old	Fever in <3month old