Assessment Guidelines for a Child in Respiratory Distress

QUALITY OF RESPIRATIONS
- Inspect the rate, depth, and respiratory effort. (See Table 25–2 for expected respiratory rate ranges by age.)
- Identify the signs of respiratory distress: tachypnea (abnormally rapid rate of respirations), retractions, nasal flaring, inspiratory stridor, expiratory grunting.
- Note lack of simultaneous chest and abdominal rise with inspiration (paradoxical breathing).
- Auscultate breath sounds. Note if they are bilateral, diminished or absent, if adventitious sounds are present (wheezes, crackles, rhonchi).
- Assess nasal patency in newborn.

QUALITY OF PULSE
- Assess the rate and rhythm. Tachycardia may indicate hypoxia.
- Compare pulse sites (apical to brachial) for strength and rate.

COLOR
- Observe overall color. With respiratory distress, color progresses from pallor to mottled to cyanosis. Central cyanosis is a late sign of respiratory distress.
- Compare peripheral and central color. Assess capillary refill and nailbed color and inspect mucous membranes. Central cyanosis in mucous membranes is more ominous.
- Note whether crying improves or worsens color.

COUGH
- Quality: note whether dry (nonproductive), wet (productive, mucousy), brassy (noisy, musical), croupy (barking, seal-like).
- Effort: note whether forceful or weak. Weak cough may indicate an airway obstruction or fatigue from prolonged respiratory effort (not valid in newborns).

BEHAVIOR CHANGE
- Note level of consciousness. Lethargy may indicate hypoxia.
- Restlessness and irritability are associated with hypoxia.
- Watch for abrupt behavior changes. Restlessness, irritability, and lowered level of consciousness may indicate increasing hypoxia.

SIGNS OF DEHYDRATION
- Inspect for dry mucous membranes, lack of tears, poor skin turgor, sunken fontanel in an infant, and decreased urine output, which indicate that fluid needs are not being met.