HIGH-YIELD REVIEW

NGN NCLEX · 2026

Pediatric *Emergencies*.

Three life-threatening presentations you *will* see on the NGN NCLEX — airway obstruction, febrile seizures, and pediatric shock. Quick recognition, key distinctions, and priority nursing actions.

VOL. 01 · EDITION A

Peds · Crit-Care

01 Airway Obstruction

PRIORITY ASSESSMENT · ABC

LIFE-THREATENING

COMMON CAUSES

What's blocking that tiny airway?

- **Foreign body** — coins, hot dogs, grapes, balloons, small toys, popcorn, nuts
- **Epiglottitis** — *H. influenzae* type B (rare post-Hib vaccine)
- **Croup** (laryngotracheobronchitis) — viral, barky cough
- **Anaphylaxis** — rapid swelling, wheeze, hives
- RSV / bronchiolitis in infants < 2 yr

RED-FLAG SIGNS

Recognize *before* decompensation

- **Stridor** — high-pitched inspiratory sound
- Retractions (suprasternal, intercostal, subcostal)
- Nasal flaring · head bobbing
- **Tripod position** · drooling · dysphagia
- Inability to speak, cry, or cough forcefully

- Cyanosis · ↓ LOC = late, pre-arrest

INFANT · < 1 YEAR

5 Back Blows + 5 Chest Thrusts

→ Position prone on forearm, head lower than trunk

→ 5 back blows between scapulae with heel of hand

→ Flip supine → 5 chest thrusts (2 fingers, lower sternum)

→ NO abdominal thrusts — risk of organ injury

→ If unresponsive → begin CPR, check mouth before breaths

CHILD · 1 YEAR AND OLDER

Abdominal Thrusts (Heimlich)

→ Stand behind, fist above umbilicus, below xiphoid

→ 5 quick inward & upward thrusts

→ Repeat until object clears or child unresponsive

→ Unresponsive → CPR + look in mouth before ventilating

→ Never blind finger sweep — can push object deeper

! NCLEX · Priority Alert

Suspected epiglottitis? NO tongue blades, NO throat exam, NO IV attempts, NO lying flat. Keep child calm on parent's lap — agitation can fully obstruct. Prepare for emergent intubation in OR.

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02 Febrile Seizures

NEURO · PEDIATRIC

⚡ MOST COMMON PEDS SEIZURE

◉ THE PROFILE

Who, when, why?

- Ages **6 months – 5 years** (peak 12–18 mo)

◉ DURING THE SEIZURE

Priority nursing actions

- **Side-lying position** — protects airway

- Temp usually **> 38.9°C (102°F)**
- Triggered by rapid rise in temperature, not the peak
- Often the *first* sign of illness in a toddler
- Genetic predisposition — family history is common

- Loosen tight clothing · clear area of hazards
- **Time the seizure** · observe characteristics
- Do NOT restrain · Do NOT put anything in mouth
- Stay with child · call for help · suction ready
- Post-ictal sleep is *normal* — do not disturb

SIMPLE · BENIGN

Simple Febrile Seizure

- → Duration **< 15 minutes**
- → Generalized tonic-clonic
- → Occurs only ONCE in 24 hours
- → No focal features · returns to baseline
- → ~98% outgrow by age 5 — low epilepsy risk

COMPLEX · CONCERNING

Complex Febrile Seizure

- → Duration **> 15 minutes**
- → Focal features (one side of body)
- → Recurs within 24 hours
- → Prolonged post-ictal state
- → ↑ future epilepsy risk → workup warranted

TEACH PARENTS

Antipyretics don't prevent recurrence

Acetaminophen & ibuprofen treat *comfort*, not seizures. Schedule dosing is NOT recommended for prevention.

CALL 911 IF…

- Seizure lasts > 5 minutes
- Difficulty breathing or cyanosis
- First-ever seizure or injury occurs
- Doesn't return to baseline

RED FLAGS

- Stiff neck · bulging fontanelle
- Petechial rash · altered LOC
- Recent head trauma
- < 6 mo or > 5 yr → think meningitis

03

HEMODYNAMIC COLLAPSE

Pediatric Shock

TACHYCARDIA = FIRST SIGN

Kids *compensate beautifully* — then crash hard. They maintain blood pressure until the very end. **Hypotension is a LATE, OMINOUS finding.** Recognize early shock before decompensation.

① HYPOVOLEMIC

Most common in kids

- Dehydration (GE, DKA, burns)
- Hemorrhage (trauma)
- Tx: **20 mL/kg NS bolus**, reassess, repeat × 2–3 if needed

② DISTRIBUTIVE

Vasodilation

- **Septic** — fever, warm/flushed early, cold late
- Anaphylactic — give **IM epi 0.01 mg/kg** (max 0.3)
- Neurogenic — spinal injury

③ CARDIOGENIC / OBSTRUCTIVE

Pump failure

- Congenital heart disease, myocarditis
- Tamponade, tension pneumo, PE
- **Fluids cautiously** — can worsen

COMPENSATED · RECOGNIZE NOW

Early Shock

→ **Tachycardia** — the FIRST and most sensitive sign

→ Cool, pale extremities · mottling

→ Cap refill **> 2 seconds**

→ Weak peripheral pulses, strong central pulses

→ Anxiety, irritability, or lethargy

→ **BP STILL NORMAL** — don't be fooled

DECOMPENSATED · PRE-ARREST

Late Shock

→ **Hypotension** — late, ominous

→ Altered LOC, unresponsive

→ Cap refill > 4 sec, mottled skin

→ Absent peripheral pulses

→ **Bradycardia** = imminent cardiac arrest

→ ↓ urine output → anuria

◉ NORMAL PEDIATRIC VITALS · AGE-BASED NORMS — HR · RR · SYSTOLIC BP

AGE GROUP	HEART RATE	RESP RATE	SYSTOLIC BP
Infant (< 1 yr)	100–160	30–60	70–100
Toddler (1–3 yr)	90–150	24–40	80–110
Preschool (3–6 yr)	80–140	22–34	80–110
School age (6–12)	70–120	18–30	85–120
Adolescent (>12)	60–100	12–20	90–120

+ Priority Management · ABCDE

Airway/Breathing → high-flow O_2. Circulation → IV × 2 large bore or IO after 90 sec if unable. Give 20 mL/kg isotonic bolus (NS or LR), reassess after each. Urine output goal › 1 mL/kg/hr (infants/children), › 0.5 mL/kg/hr (adolescents). Septic shock → antibiotics within 1 hour.

◆◆◆ NCLEX MEMORY AIDS ◆◆◆

Commit these to memory.

4 Don'ts

Epiglottitis

D on't examine the throat

S-T-O-P

During a seizure

S tay with child · ***S*** ide-lying

TIRED

Early shock signs

T achycardia (first!)

D on't lay flat — tripod is comfort

D on't agitate — keep with parent

D on't delay OR intubation

T ime it · note features

O pen airway (head tilt only if needed)

P rotect — clear area, no restraints

I rritability / altered LOC

R efill capillary > 2 sec

E xtremities cool/mottled

D ecreased urine output