PAIRS

PAEDIATRIC ACUTE INTERVENTION RESUSCITATION SKILLS GROUP

Paediatric

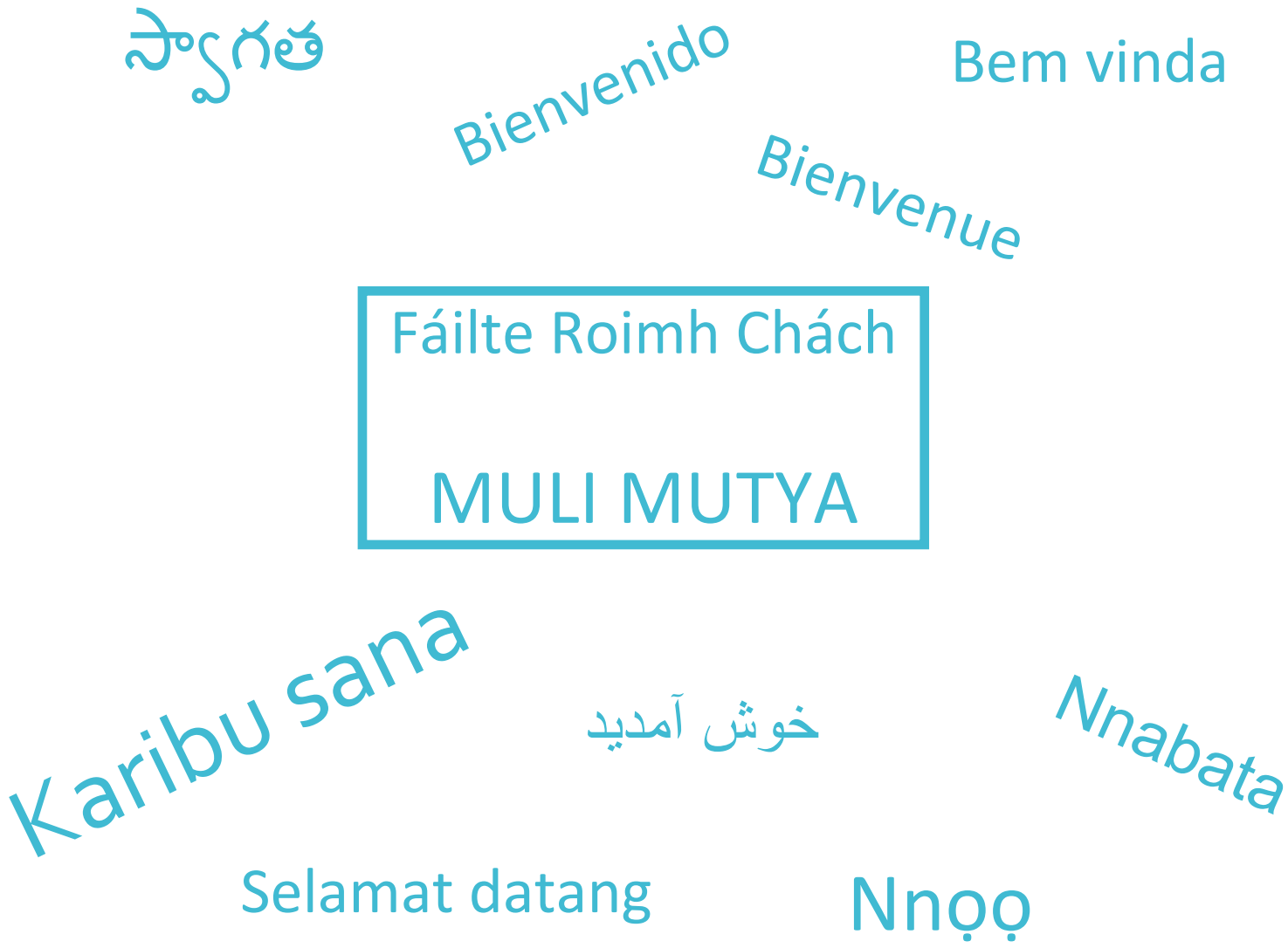
Acute

Intervention

Resuscitation

Skills

Welcome back to PAIRS two-day course



Re-introductions & Reflections

Housekeeping

Groupings

Telephone use

Break times

Lunch arrangements

Toilet facilities

Background

<5 mortality rate: 40.5 Deaths per 1,000 live births

17.4 per 1,000 live births have neonate sepsis

Low workforce to patient ratio

- Basic knowledge & skill can prevent this
- Desire to learn
- Focus on most important basics
- Build on skills and knowledge

Learning outcomes

Building on Day 1 . . .

- Recognition of a sick child
- ABCDE structured assessment

- Basic/advanced intervention
- Reassessment

- Effective communication – safety huddle
- Work effectively as a team

Course programme

CPR+/Collapsed Child

- Team dynamics & advanced algorithms

Advanced skills

- Airway / Circulation / Vital Signs / Communication/Neonatal Resuscitation

Cases

- Simulation practice *plus* testing (MCQ)

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Summary: Cardiopulmonary Resuscitation

4S Approach

ABC

Respiratory failure

Circulatory failure

Causes of cardiac arrest in children

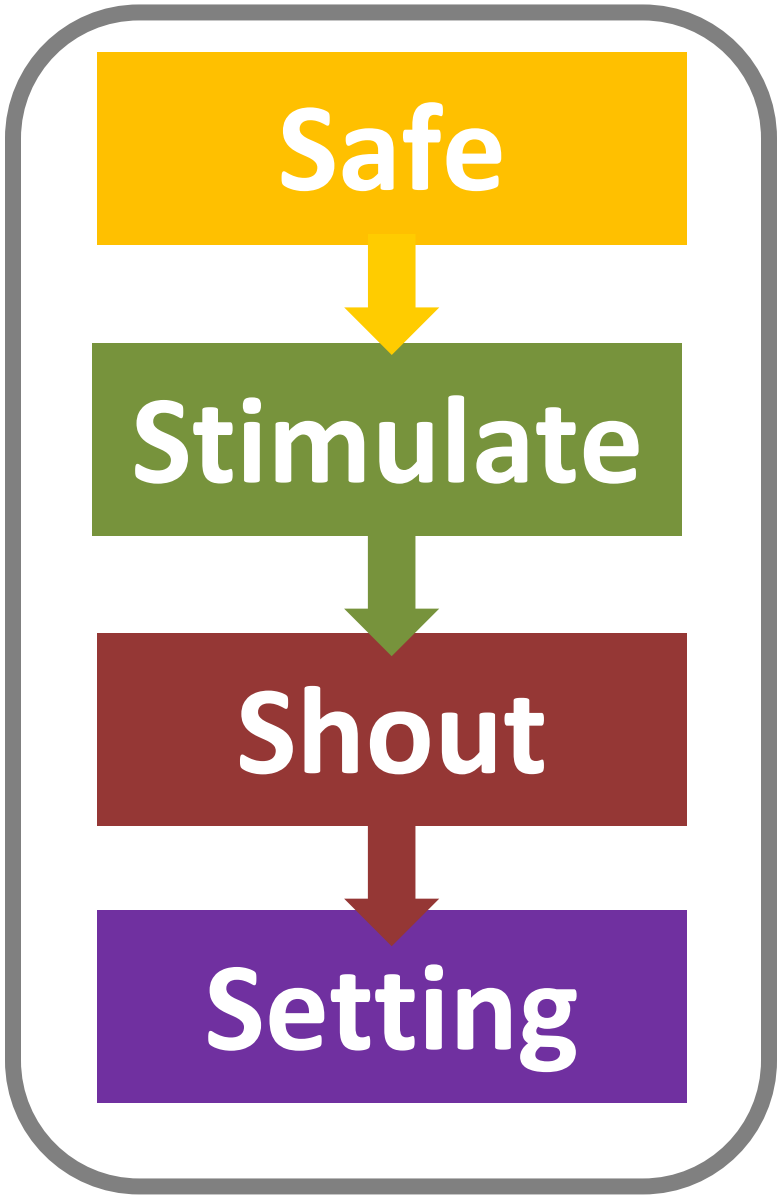
Respiratory failure

- Pneumonia
- Bronchiolitis
- Chest injuries
- Asthma
- Pleural Effusion/Empyema
- Anaphylaxis

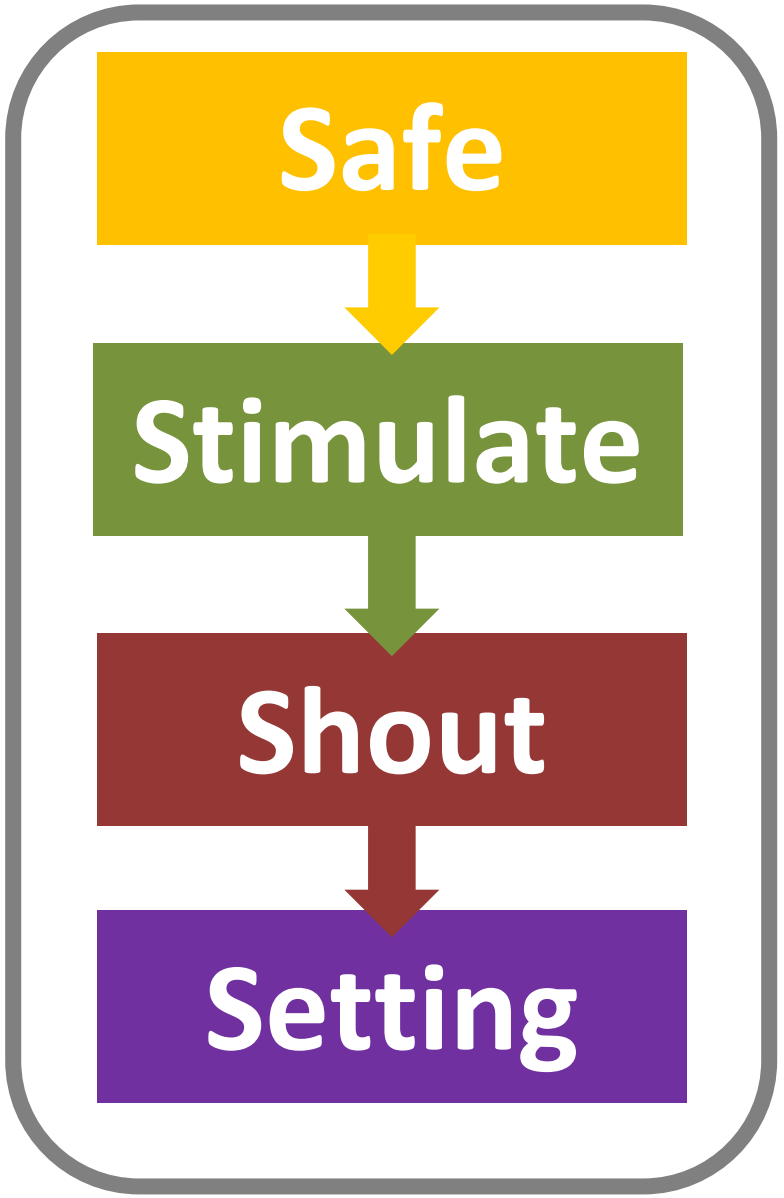
Circulatory failure

- Sepsis
- Malaria
- Gastroenteritis
- Haemorrhage
- Anaemia
- Malnutrition
- Anaphylaxis

4S CPR



4S CPR



Ensure Healthcare Providers and Patient are safe

Assess for responsiveness

Shout For Help

Is the child in the correct setting

Cardiac Arrest first steps

A & B

Check A & B

Open and clear airway

Look, Listen & Feel for breathing

Apnoea or only gasping :
5 rescue breaths

Call

Shout for help if not arriving

C

Check and Compress

Recheck A & B while checking large pulse (signs of life)

Absent pulse or <60bpm:
Start compressions

Rate of 120 per min
Ratio 15:2

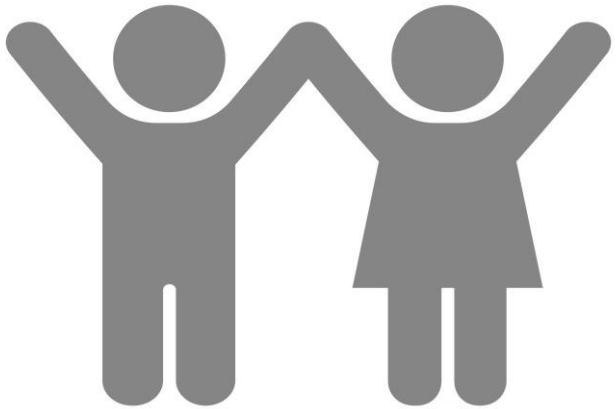
Paediatric CPR

Infant

<1 year or <10kg

Child

>1 year or >10kg



Infant BLS technique

2 thumbs → Neutral airway → Use BVM

- 120 per min
- 1/3 chest depth

Infant or child size BVM

Child BLS Technique

1 or 2 hands → Sniffing position → Child/adult BVM

- 120 per min
- 1/3 chest depth

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Management of cardiac arrest

Cardiac arrest management

Continue CPR
15 compressions : 2 breaths

Give adrenaline IV or IO during CPR
0.1ml/kg 1:10,000

Look for signs of life
Check pulse every 2 minutes
(do not interrupt CPR for more than 10 seconds)

If monitor/defibrillator available

Recognise and treat rhythm

Treat reversible causes

4H **4T**

Reversible factors

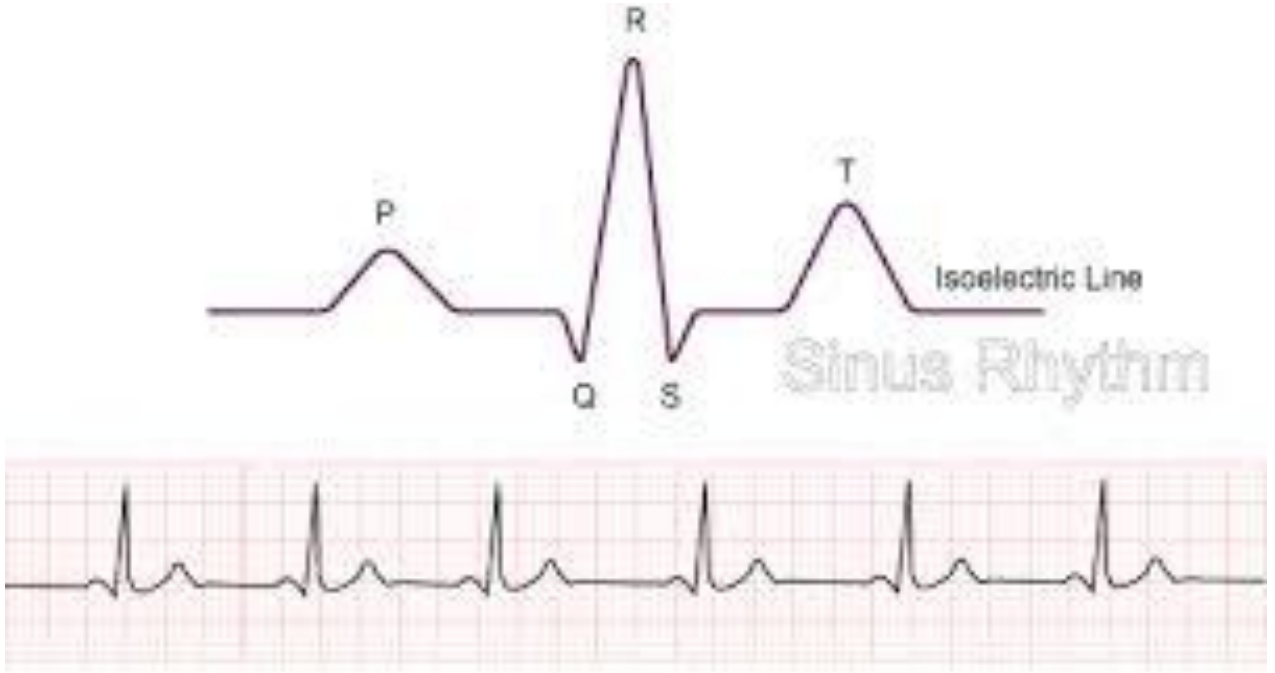
4H

- **H**ypoxia
- **H**ypovolaemia
- **H**ydrogen ions
  - **H**ypokalaemia
  - **H**yperkalaemia
  - **H**ypoglycaemia
- **H**ypothermia

4T

- **T**ension Pneumothorax
- **T**hromboembolism
- **T**oxins
- Cardiac **T**amponade

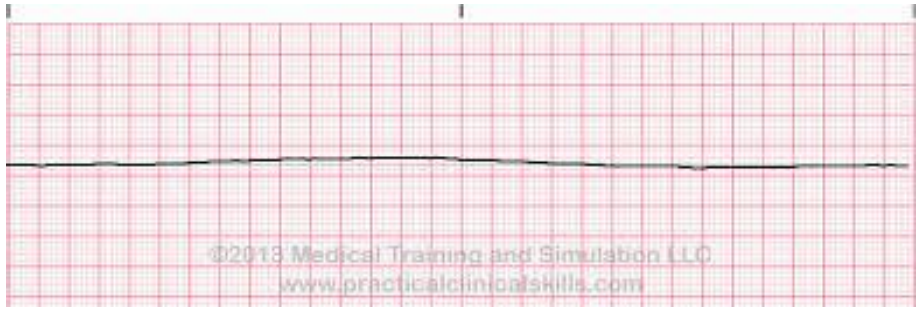
Rhythm recognition



Rhythm recognition - treatment

- Non shockable rhythm

  - asystole



Rhythm is not shockable

Continue CPR
15:2

Adrenaline IV or IO
immediately then every 4 minutes
0.1ml/kg 1:10,000

Look for signs of life
Check pulse @ 2 mins

REMEMBER
Treat H&Ts
High flow O_2
IV/IO access
Intubate

Rhythm recognition - treatment

- Non shockable rhythm

  - pulseless electrical activity (PEA)

Rhythm is <u>not</u> shockable

Continue CPR
15:2

Adrenaline IV or IO
immediately then every 4 minutes
0.1ml/kg 1:10,000

Look for signs of life
Check pulse @ 2 mins

REMEMBER
Treat H&Ts
High flow O_2
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Intubate

Rhythm recognition - treatment

- Shockable rhythm
  - Ventricular Fibrillation (VF)

Rhythm is shockable

↓

Shock 4 J/kg

↓

Recommence CPR
(minimal interruptions)

↓

Adrenaline after 3rd shock and then after every alternate shock
Amiodarone after 3rd and 5th shock

Assess rhythm after 2 mins CPR

REMEMBER
Treat H&Ts
High flow O_2
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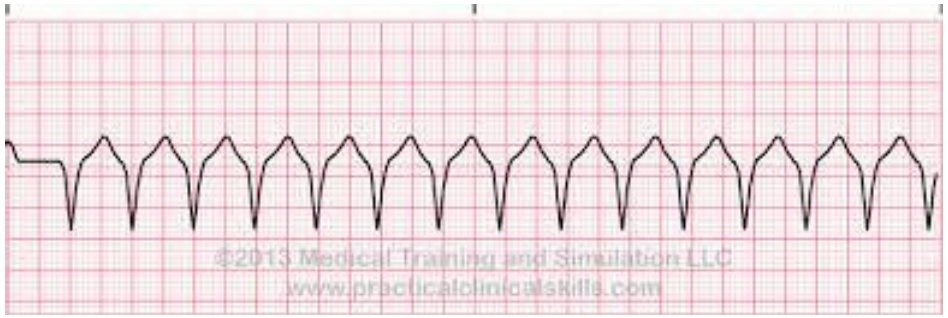
Intubate

Rhythm recognition - treatment

- Shockable rhythm
  - Ventricular Tachycardia (VT)



Rhythm is shockable

↓

Shock 4 J/kg

↓

Recommence CPR
(minimal interruptions)

↓

Adrenaline after 3rd shock and then after every alternate shock
Amiodarone after 3rd and 5th shock

Assess rhythm after 2 mins CPR

REMEMBER
Treat H&Ts
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Emergency Calculations

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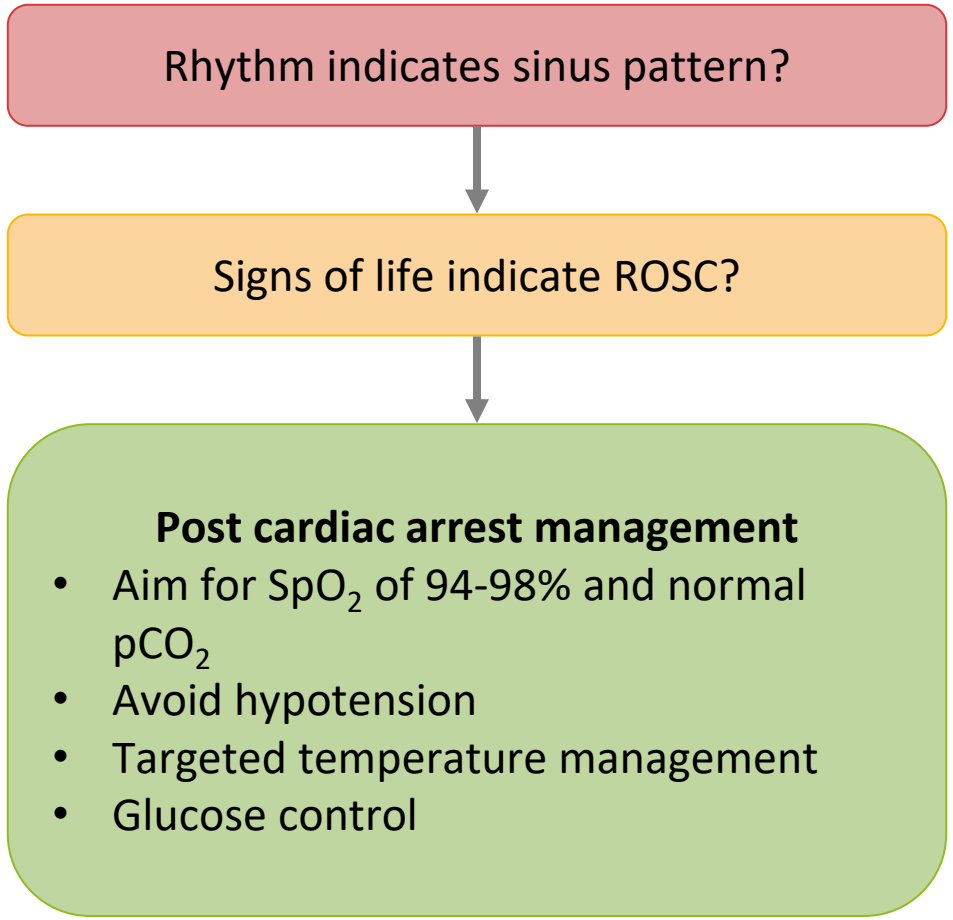
Check allergy status!

		Calculation	Unit
W	Weight	1-12months (0.5 x age in months) + 4 1-5yrs (2 x age in years) + 8 6-12yrs (3 x age in years) + 7	Kilograms
E	Energy (defibrillation)	4 J x kg weight	Joules
T	Tube size (ETT)	0 -11mths 3mm - 3.5mm Internal Diameter = Age / 4 + 4 Length (oral) = Age / 2 + 12 Length (nasal) = Age /2 + 15	Centimetres
F	Fluids	10 ml x kg weight	Millilitres
L	Lorazepam	0.1mg x kg weight	Milligrams
A	Adrenaline (cardiac arrest)	0.1ml x kg weight of 1:10,000 Adrenaline	Millilitres
A	Adrenaline (anaphylaxis)	0.01 mL/kg of 1:1000 (maximum 0.5 mL)	Millilitres
A	Amiodarone	5mg x kg weight	Milligrams
G	Glucose	3ml x kg weight of 10% Dextrose	Millilitres

Further considerations - ROSC

Return of spontaneous circulation (ROSC)



Further considerations

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Ceasing Resuscitation

- Hs and Ts should be addressed
- Unlikely to be successful if no signs of life after 20 minutes of resuscitation, in the absence of refractory VF/pVT
- Team Leader decision
  - Consult specialists as helpful/required
  - Document decisions
- Maintain dignity and respect for child and family

Further considerations

Family presence during resuscitation

- Allocate a designated staff member to support & interpret events
- Team Leader has responsibility for decisions
- If family presence is impeding medical efforts, parents may be sensitively asked to leave – with support
- After the event, a debriefing session to support staff and reflect on practice is very beneficial

Further considerations

Debriefing

- ‘Hot debrief’ occurs soon after an event
  - Identify learning
  - Allows a check in with staff

- ‘Cold debrief’ occurs some time after event
  - Facilitated session
  - Identify learning & key pointers for the future

Summary cardiac arrest management

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Continue CPR
15 compressions : 2 breaths

Give adrenaline IV or IO during CPR
0.1ml/kg 1:10,000

Look for signs of life
Check pulse every 2 minutes
(do not interrupt CPR for more than 10 seconds)

If monitor/defibrillator available

Recognise and treat rhythm

NON shockable
- Asystole
- PEA
- No monitor

Shockable
- VF
- VT (no pulse)

REMEMBER
Treat H&Ts
High flow O_2
IV/IO access
Intubate

ROSC
- Post cardiac arrest care

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Time to practice!
CPR | Safe defibrillation

Break time!

Team dynamics

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Team dynamics

- Human factors affect the performance of the resuscitation team
- Training can help to improve communication, team dynamics, role identification and task delegation

Team dynamics

Qualities of a “poor” Resuscitation Event:

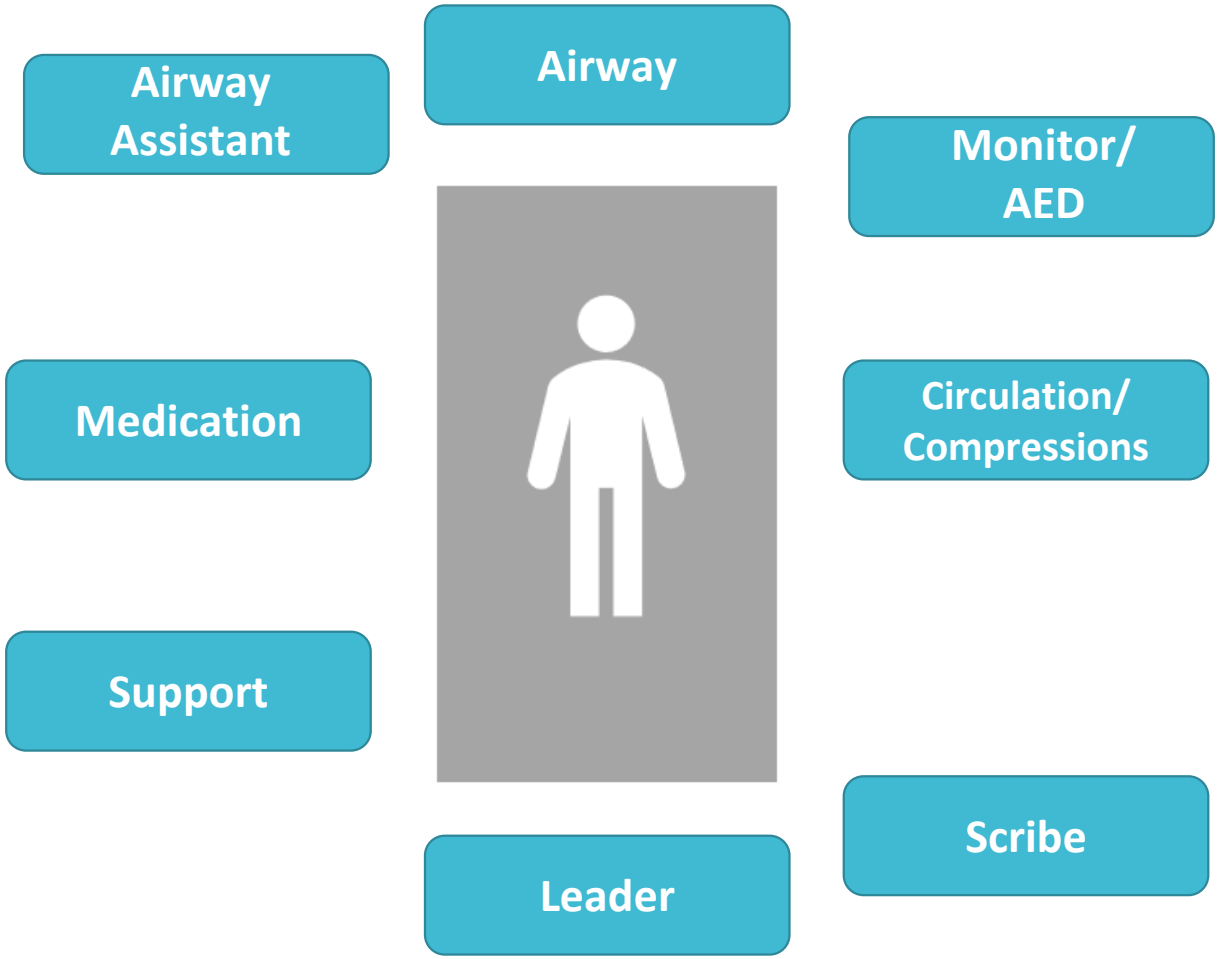
- Chaos
- No defined leader
- Conflict among leaders or over leadership
- Confusing and/or inaccurate communication
- Deviation from standard guidelines
- Loud
- Crowded
- Safety issues

Team dynamics

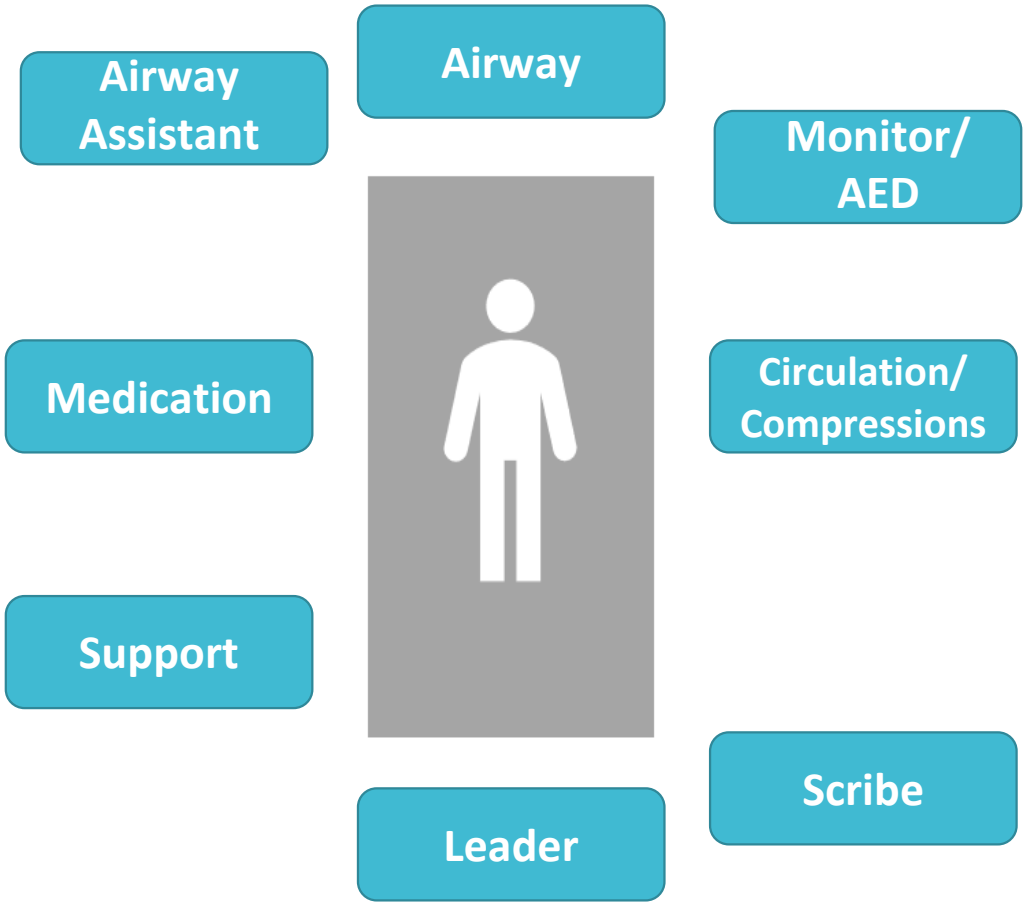
Qualities of a “good” Resuscitation Event:

- Closed loop communication
- Clear messages
- Clear roles & responsibilities
- Knowing limitations
- Knowledge sharing
- Constructive intervention
- Re-evaluation & summarising
- Mutual respect

Resuscitation Team Roles



Resuscitation Team Roles



- Clear roles and responsibilities
- Knowing limitations
- Constructive interventions
- Knowledge sharing summarising and re evaluating
- Closed loop communication
- Clear messages
- Mutual respect

Resuscitation Team Roles

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Leader

Resuscitation Team Roles

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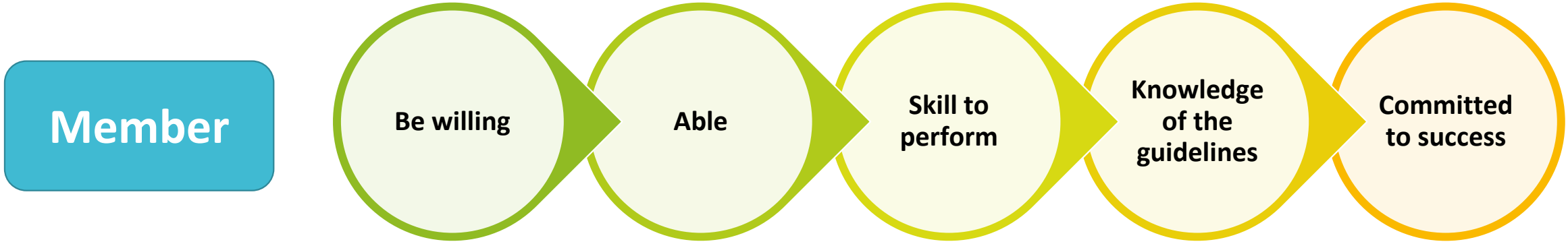
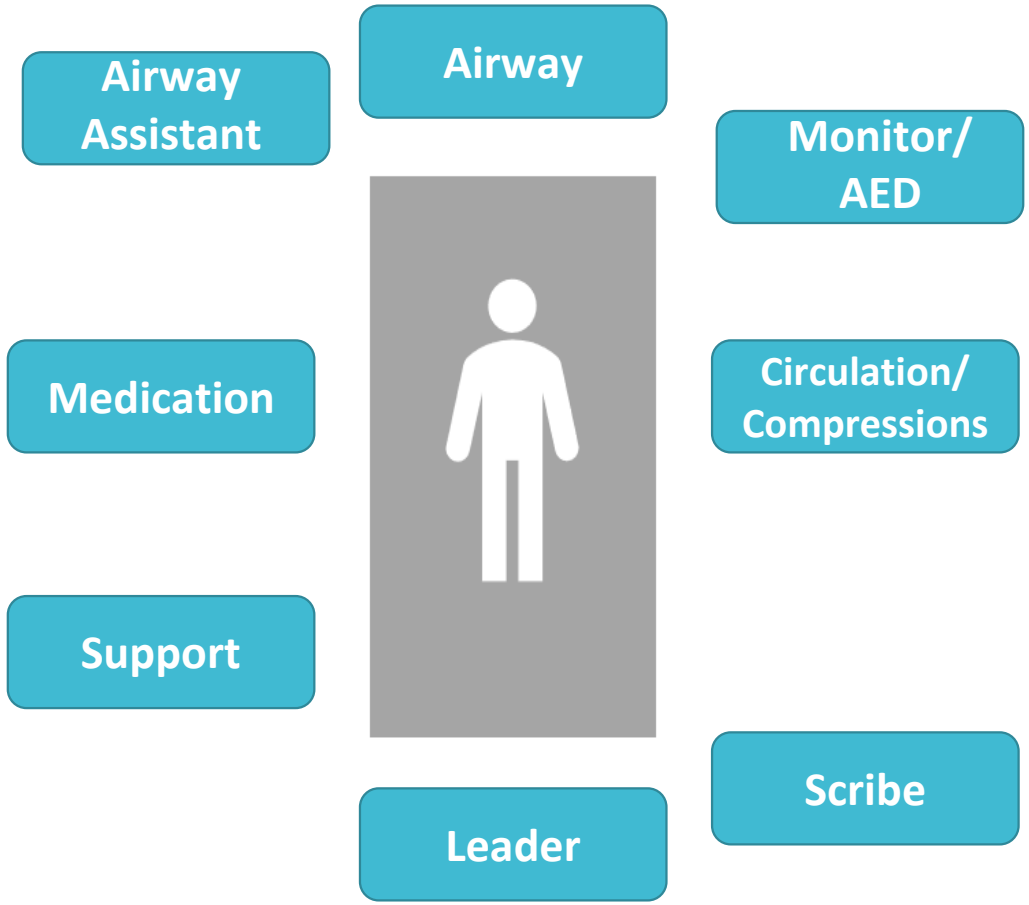


Resuscitation Team Roles



- Airway Practitioner and Assistant
- Circulation/Compressions
- Monitor/AED
- Assessment/Medication
- Scribe
- Runner/Family support/Other

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Questions?

Summary

- Continuous, effective CPR & ventilation
- Identify & treat rhythm
- Treat reversible causes
- Seek senior paediatric advice early
- Work as an effective team

Team Dynamics Demonstration

Time to practice!

Shockable	Non-shockable

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Lunch time

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Summary Assessment & Management of Deterioration

ABCDE

What could we have done differently for Joseph?

- Identify the seriousness of the deterioration in Joseph's clinical condition
- Intervene early
- Communicate effectively
- Vital Signs Documentation
- Plan appropriate management
- Escalate care promptly

Improvement ideas

1

Education and training must be provided to ensure staff are competent

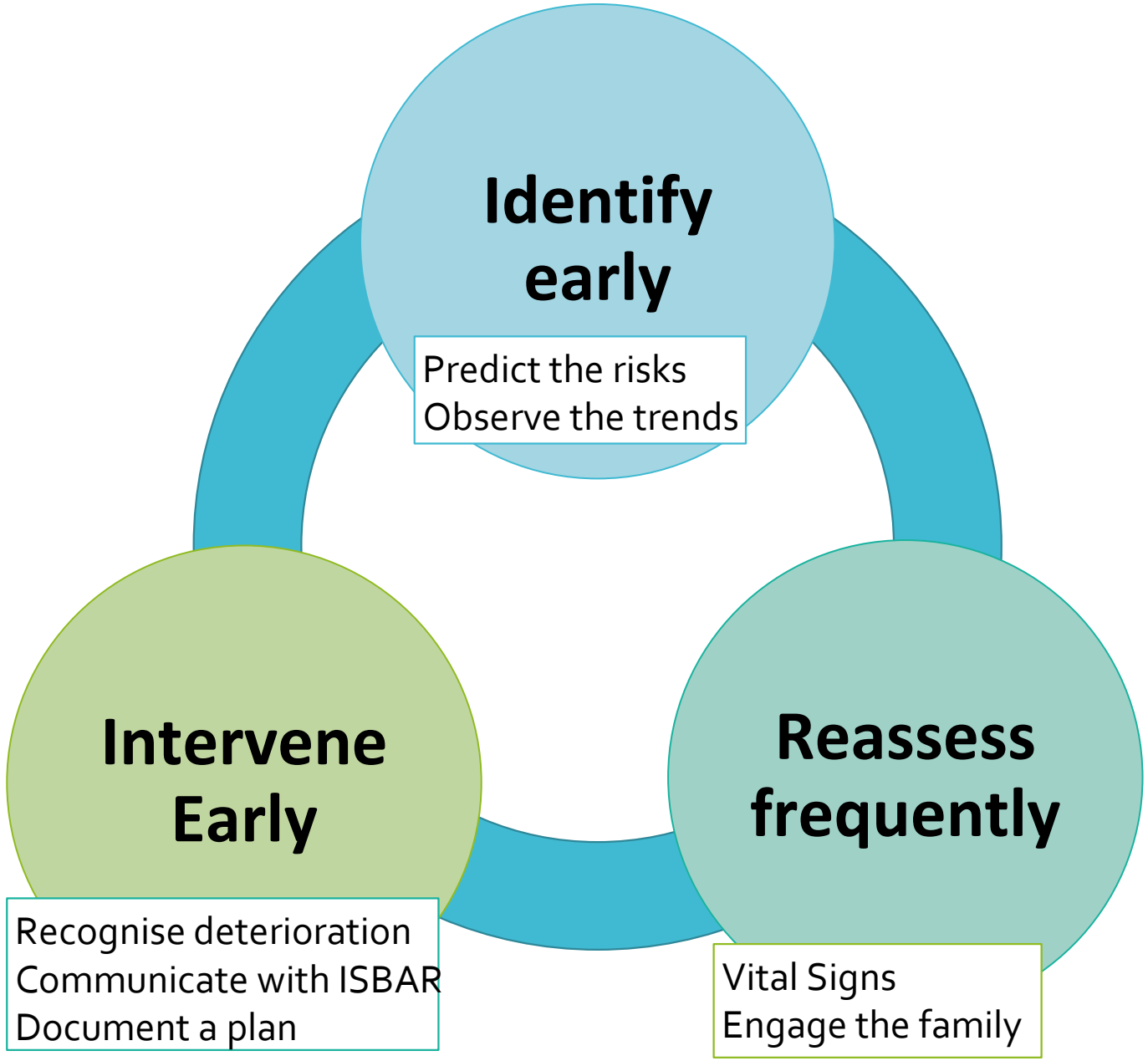
2

Vital signs must be recorded using PEWS

3

Timely call for help should occur when indicated

Acute Illness Intervention Cycle



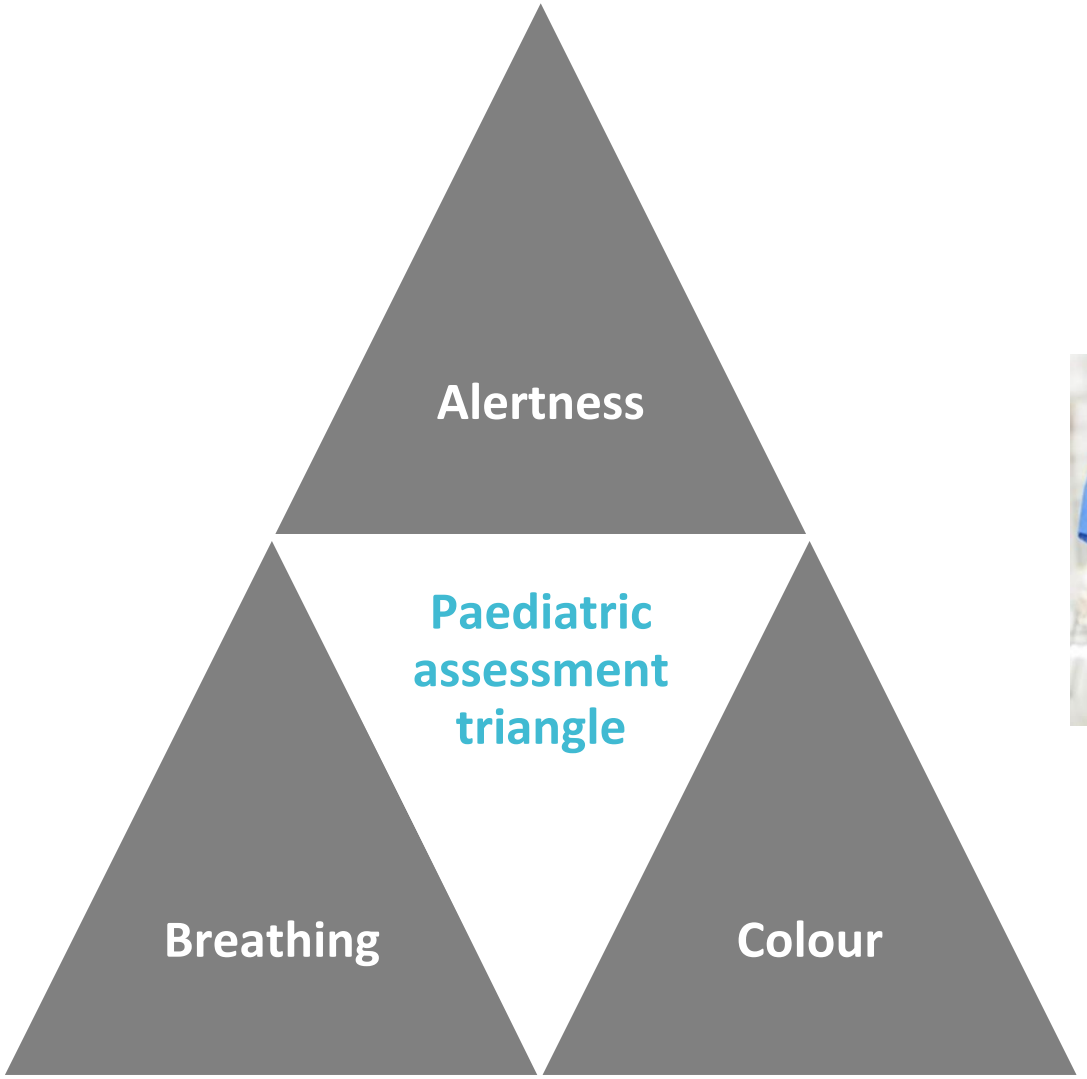
High Risk Groups

- <3 months old
- Prematurity
- Pre-existing conditions
  - Asthma
  - Diabetes
  - Sickle Cell Disease
  - Cancer
  - Malnutrition
  - HIV

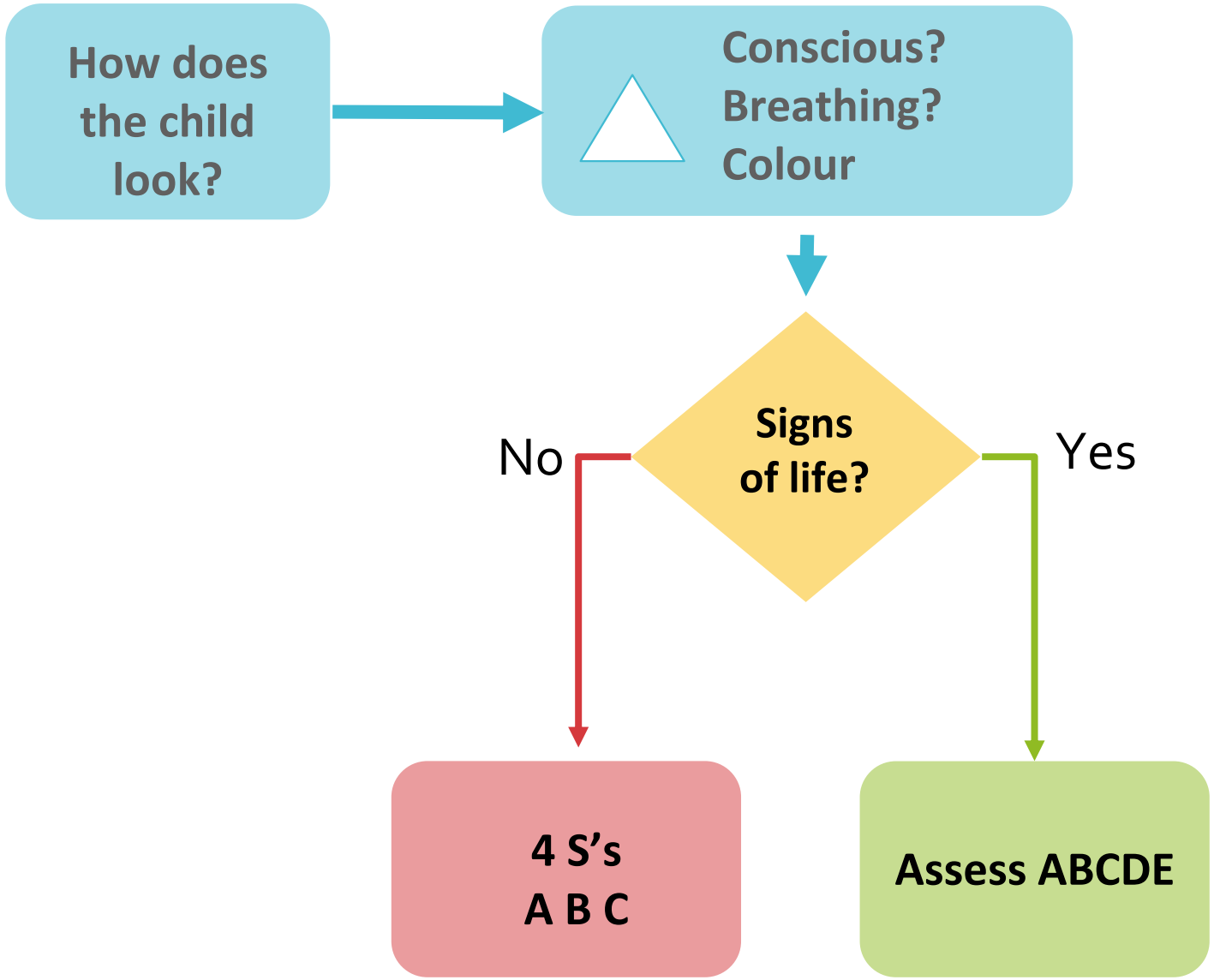
Children Are Different

- Different physiology, anatomy and psychology
- Children initially compensate and can quickly deteriorate
- Talk to parents – They know their children

Structured Assessment



Structured Assessment

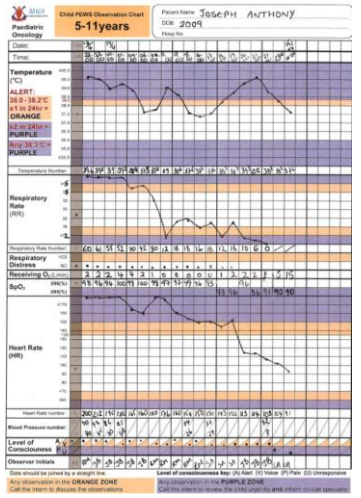


Summary ABCDE assessment

Airway check for patency	Stridor / cyanosis	Opening & clearance techniques
Breathing check for distress	Grunting / stridor / hypoventilation / low SpO_2	Relief of distress & support ventilation
Circulation check for compromise	Hypotension Weak or irregular pulses	Appropriate fluid & drug administration
Disability check for neurological issue	Manage pain, ↓LOC, seizures	Manage pain, ↓LOC, seizures
Exposure check for everything else	Deal with bleeding, rash or trauma	Deal with bleeding, rash or trauma

Monitoring

- Repeat assessment regularly
- Agree action plan
- Decide how to monitor
  - SpO_2 continuously or intermittent?
  - BP set to automatic or intermittent?
  - Move to a closer bed?
  - Access to ECG monitor?
- Ask parent or child to help



Referral & Escalation

- Always use clinical judgement
- Review child regularly
- Act on concern
- Be aware of non-improvement & the child who is tiring

- Who can you call?
- Record all decisions & actions

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Communicate effectively

ISBAR

Identify

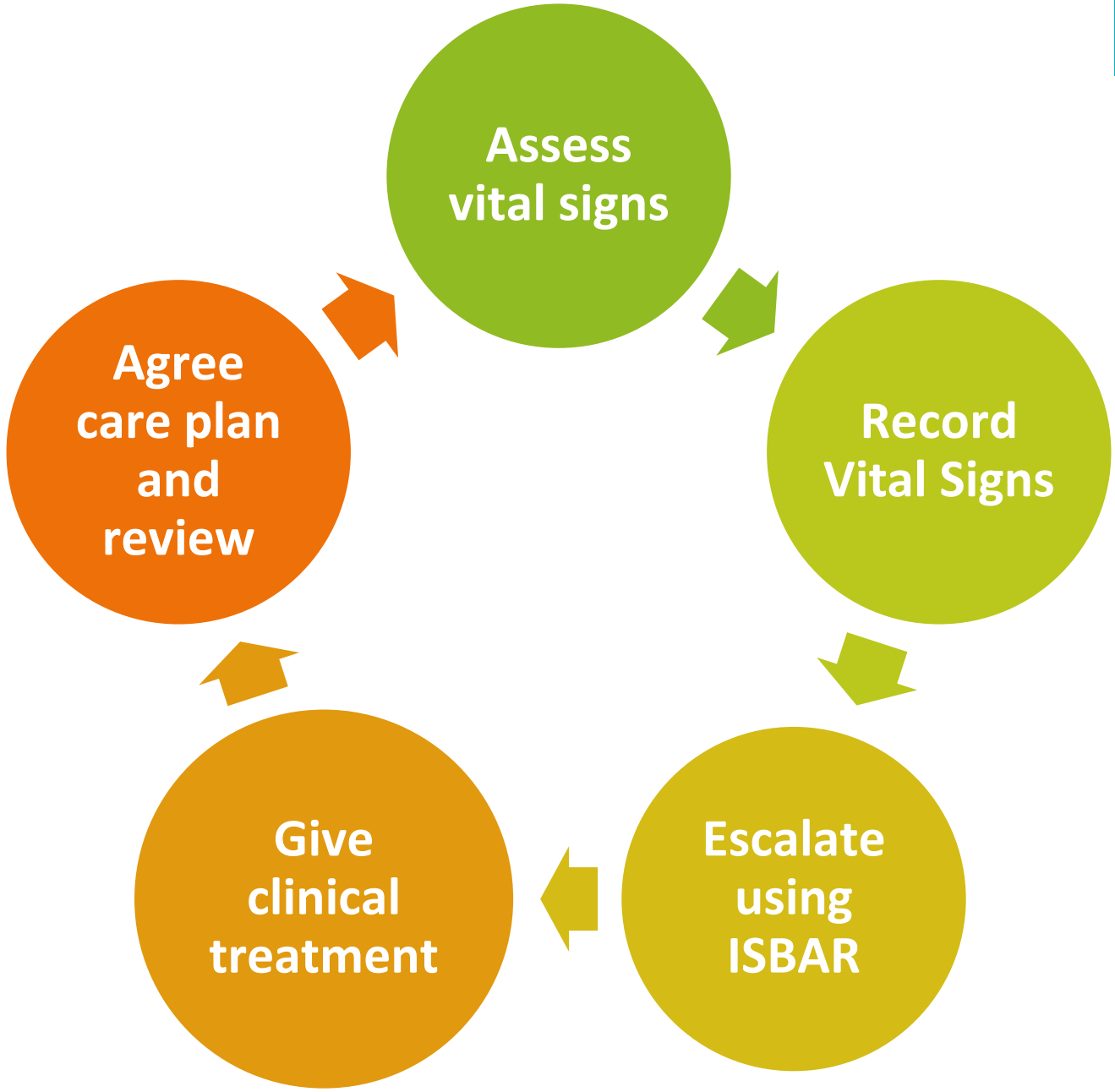
Situation

Background

Assessment

Recommendation

Reassess frequently



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Introducing the safety huddle

Communicate effectively

The **safety huddle** is…

- A core safety intervention to
  - Increase situation awareness
  - Improve team communication
- Short
- Structured
- Takes a team to implement

The huddle rules

1. Always occurs in the same place at the same time
2. Start & finish on time (max 10 minutes)
3. The Huddle is protected, with no interruptions
4. Attendance is monitored to ensure compliance
5. Everyone’s contribution is equally valuable

The huddle script

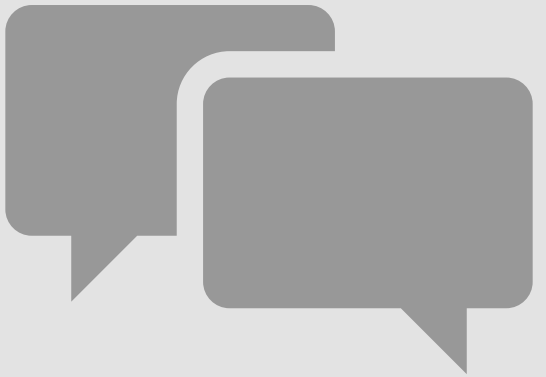
1. Standardised introduction
2. Are there any patients at risk of deterioration?
   - Why is the patient at risk?
   - What is the management plan?
   - Who should their care be escalated to?
3. Does anybody wish to identify any other concerns which have not been raised, or offer a different perspective on anything we've discussed?
4. Standardised closure of the huddle

The huddle ‘Watcher’

Identify patients who do not have worrying vital signs but who the team may feel is at risk of getting sicker:

- A gut feeling or instinct
- Family have expressed concern
- Communication concerns around the patient’s care
- Patient is on high-risk or unfamiliar treatment

Would a Safety Huddle be useful in your place of work?



Summary

- Recognise the risk of acute illness in children (**ABCDE**, **Vital Signs**)
- Communicate effectively with **ISBAR**
- Follow the **acute illness intervention** cycle to identify, intervene and reassess
- Discuss and record the **plan** of care
- Consider implementing a safety huddle

Skill stations

- Advanced airway & breathing
- Advanced circulation
- Advanced communication
- Advanced Neonatal Resuscitation

Airway/Breathing DAY 2

Acute Respiratory Distress in Children

Objectives

- Identify and manage childhood illnesses presenting with respiratory distress
- Describe pneumonia management
- Explain asthma treatment strategies

Causes of Respiratory Distress

Lung & Airway Diseases:

- Pneumonia (bacterial, viral, fungal)
  - Tuberculosis (TB)
  - HIV-PCP (Pneumocystis)
- Asthma
- Bronchiolitis
- Croup (LTB)
- Foreign body aspiration

Systemic Causes:

- Severe Malaria
- Severe Anaemia
- Severe Dehydration
- Cardiac Disease
- Renal Disease

Pneumonia Classification

- Pneumonia is classified by cause (bacterial, viral, fungal) and severity
- Severity is assessed using clinical signs
  - Tachypneoa
  - Chest indrawing
  - Cyanosis
  - Level of consciousness
- Two categories: Severe Pneumonia & Pneumonia (Mild-Moderate)

Severe Pneumonia

Criteria for Severe Pneumonia:

Oxygen saturation <90%(cyanosis)
Unable to drink or feed
Reduced level of consciousness
Grunting (infants)

→ Severe Pneumonia

Lower chest wall indrawing
RR- ≥50 breaths/min (2–11 months)
RR - ≥40 breaths/min (1–4 years)

→ Pneumonia

None of the above

→ No Pneumonia

Non-Severe Pneumonia (Mild-Moderate)

Lower chest wall indrawing
RR ≥ 50 aged 2 –11 months
RR ≥ 40 aged 1 – 4 yrs

- Treat with dispersible amoxicillin
- Outpatient management if feeding well.
- Follow up in 2-3 days to check for improvement.
- Seek medical attention if symptoms worsen (inability to drink, difficulty breathing).

Management of Severe Pneumonia

- ***Cyanosed/oxygen sat <90%?***
- ***Unable to drink?***
- ***Reduced level of consciousness?***
- ***Grunting (infants)?***

Hospital Management:

- - Oxygen therapy (if SpO_2 <90%)
- -IV antibiotics:
- - 1st line: Benzylpenicillin/Ampicillin + Gentamicin.
- - 2nd line: Ceftriaxone + Cloxacillin
- - Supportive care: IV fluids, nutrition support
- - Close monitoring for deterioration.

Asthma Classification

Asthma severity is assessed using clinical signs:

- Mild-Moderate Asthma: Wheezing, difficulty breathing but can talk.
- Severe Asthma: SpO_2 <90%, speaks in words only, chest indrawing.
- Life-Threatening Asthma: Silent chest, cyanosis, drowsy or confused.

Management of Asthma

Mild-Moderate Asthma:

- Nebulized Salbutamol or inhaler with spacer + mask.
- Oral/MDI Steroids if necessary.
- Reassess after 20-60 minutes.

Severe Asthma:

- Oxygen therapy
- Nebulized Salbutamol + Ipratropium
- Steroids (Oral/IV/MDI)
- Consider Magnesium Sulphate
- Reassess frequently.

Life-Threatening Asthma

- Urgent ICU referral
- Aggressive oxygen therapy.
- Continuous salbutamol nebulization
- IV hydrocortisone or oral prednisolone

Administering Salbutamol

Nebulizer

- 2.5 mg for children <5 years.
- Up to 3 doses in first 1 hour, reassess after each dose

Inhaler + Spacer + Mask for children <5 years

- 1 puff per 5-6 breaths every 3 minutes (Max 10 puffs in 30 min)

Summary

- Use clinical signs to assess respiratory distress severity.
- Initiate oxygen therapy if SpO_2 <90%
- Severe pneumonia: Hospitalize, start IV antibiotics.
- Mild pneumonia: Treat with amoxicillin po
- Asthma: Manage with salbutamol + steroids and reassess frequently

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Acute
Illness
Resuscitation
Skills

Advanced Newborn Resuscitation

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Objectives

- Core knowledge of newborn resuscitation
- Recognition of newborn who is not breathing
- Practical interventions required
- Focus on ‘Golden Minute’

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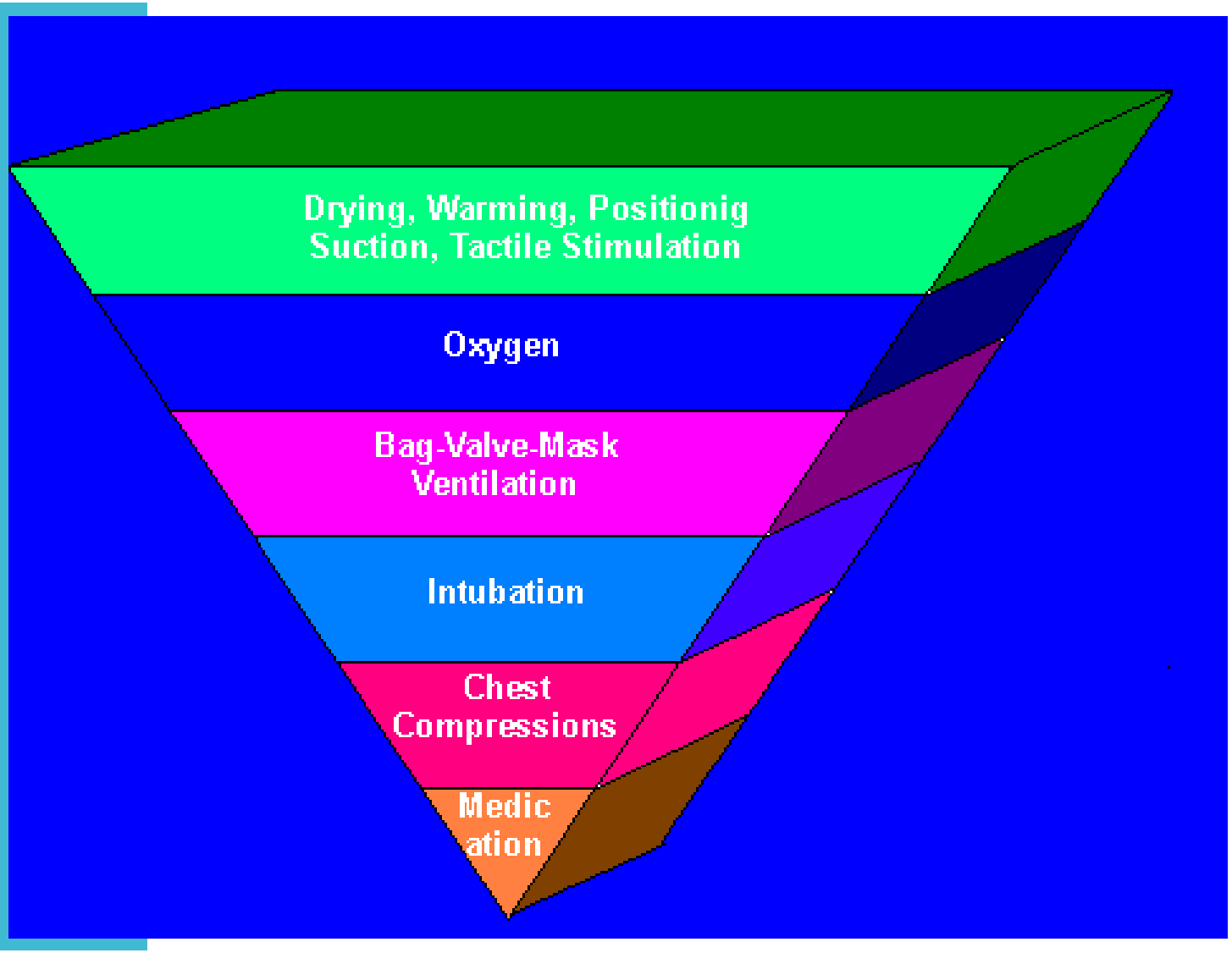

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Preparing for Newborn Resuscitation

Essential Equipment

Warmth:

- Overhead Warmer
- Warm, Dry Towels
- Stable Surface and Proper Lighting
- Clock/timer

Airway and Breathing:

- Suitable Bag-Valve-Mask (BVM).
- Suction Device
- Pulse Oximeter

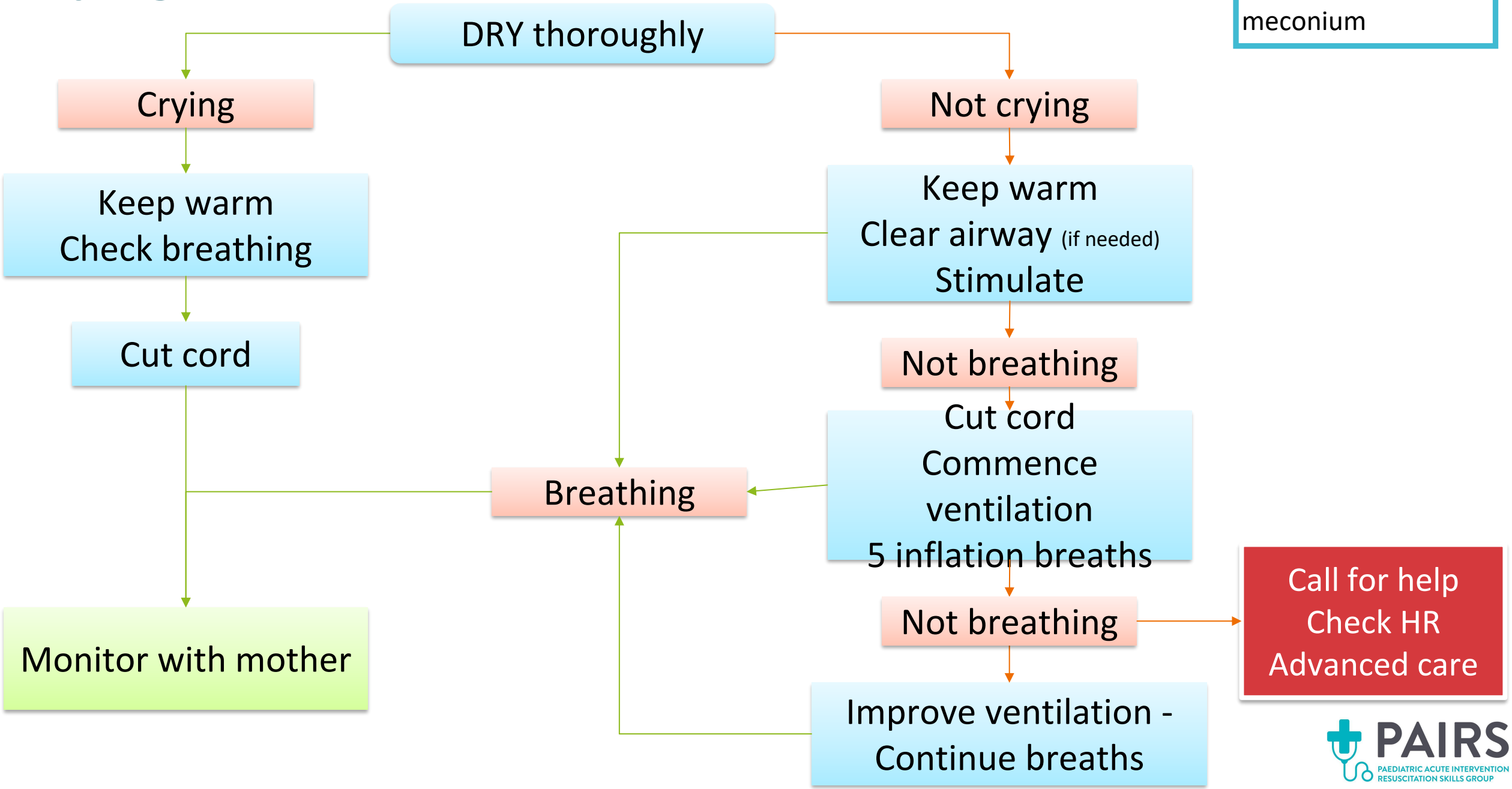
Medications and Other Supplies:

- Gloves
- Umbilical access supplies

If the hospital can provide advanced care-
Laryngoscope, ET tubes, Scissors and tape
Drugs-Adrenaline, IV Fluid (Volume)

Helping Babies Breathe

*In the absence of meconium



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Helping Babies Breathe

DRY thoroughly

Crying

Keep warm

Che

Start the clock

Not crying

Keep warm
Clear airway (if needed)
Stimulate

Not breathing

Golden minute

Initiate ventilation - 5 slow breaths
Continue ventilation at 40-60 breaths/min for 60 seconds
Feel for HR when help arrives

Heart Rate < 60 / min

Advanced Care

Heart Rate > 60 / min

Continue ventilation

Reassess ABC

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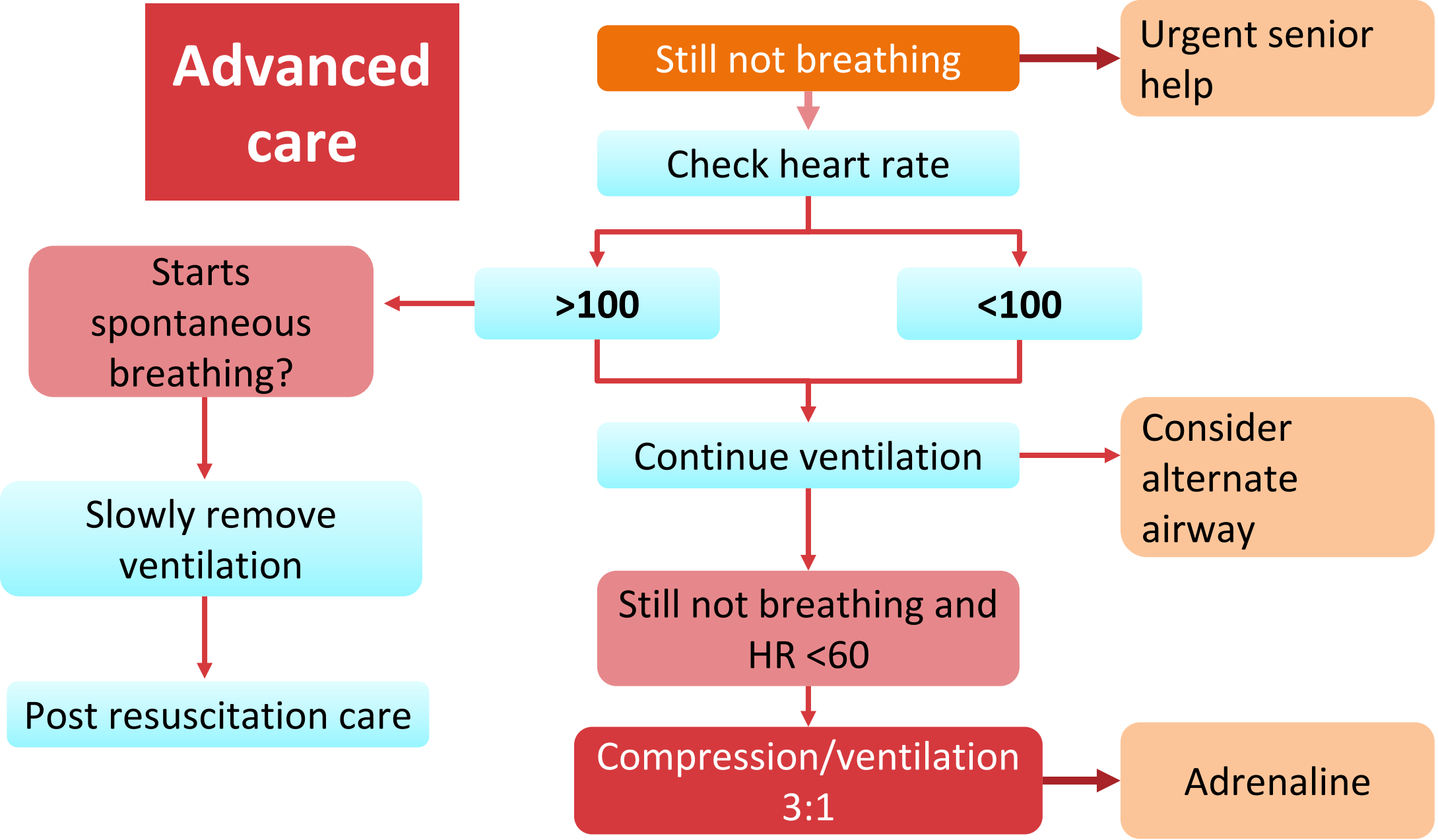
Helping Babies Breathe



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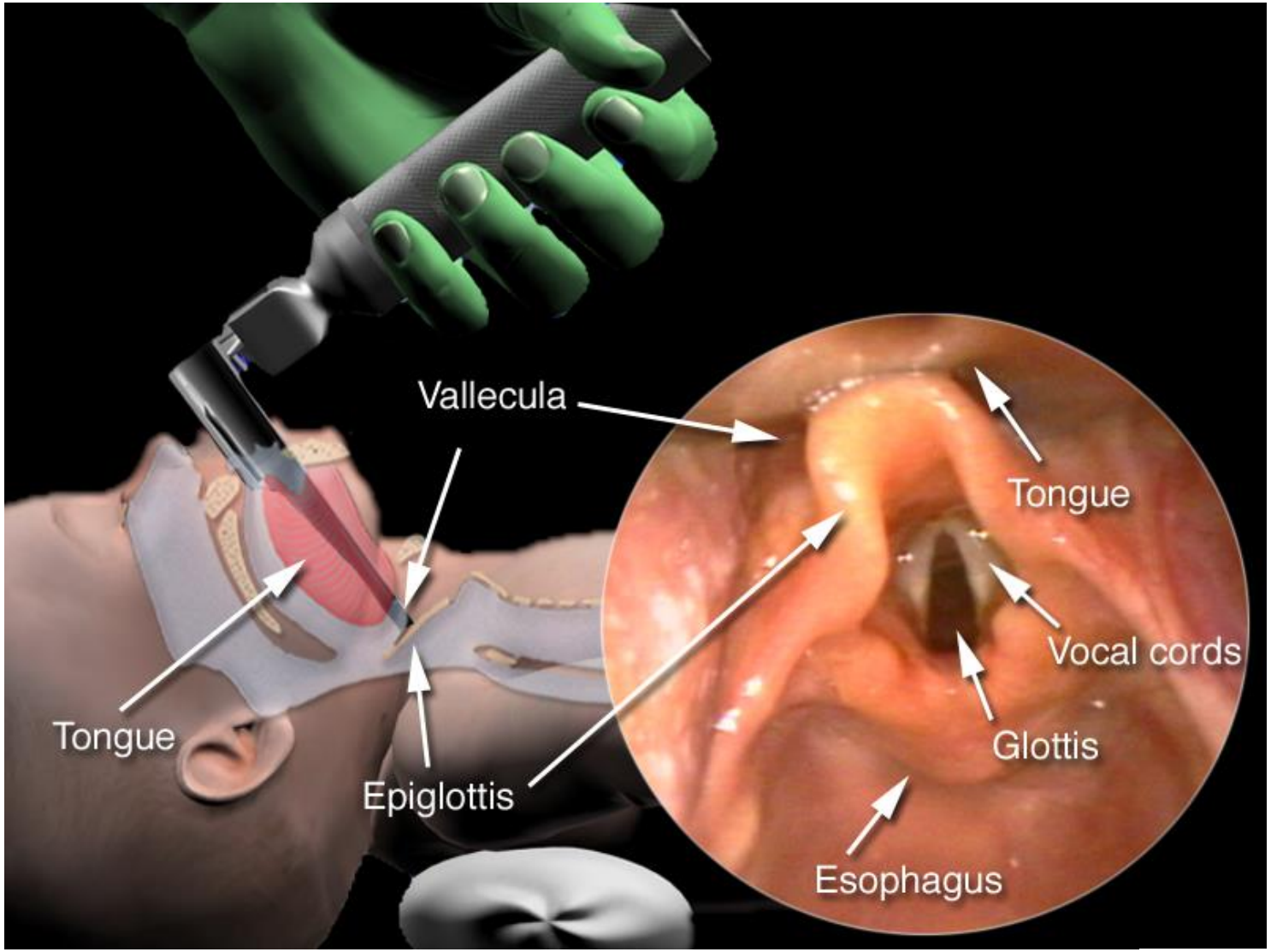
Endotracheal Intubation: Anatomic Landmarks



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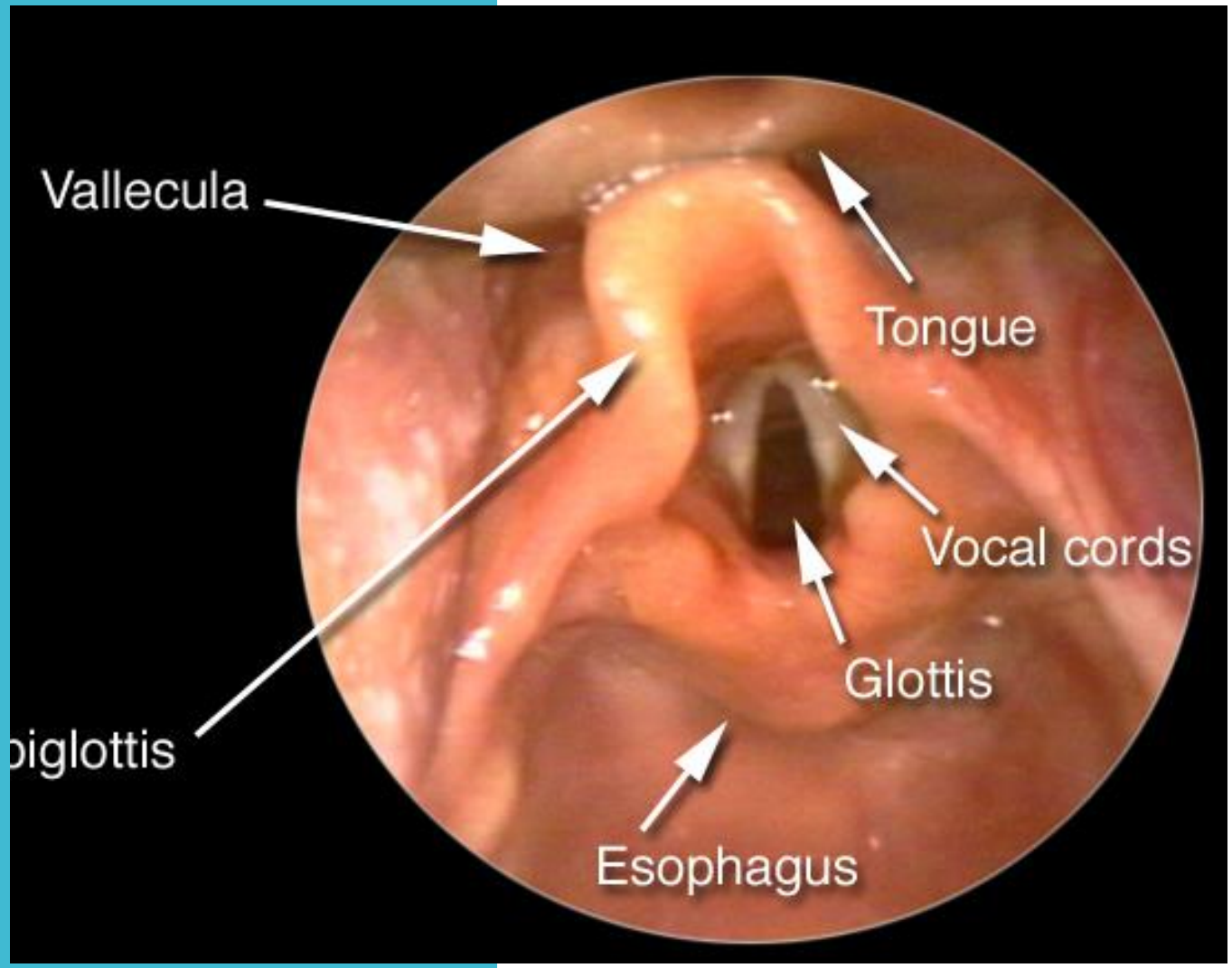

Endotracheal Intubation: Visualize Landmarks

- Vocal cords should appear as vertical stripes on each side of the glottis or as an inverted letter "V"
- Applying downward pressure on cricoid may help bring glottis into view
- Suction, if necessary, for visualization

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Endotracheal Intubation: Checking Tube Position

Signs of correct tube position

- Improved vital signs (heart rate, color, and activity)
- Presence of exhaled CO_2 as determined by CO_2 detector
- Breath sounds over both lung fields but decreased or absent over stomach
- No gastric distention with ventilation

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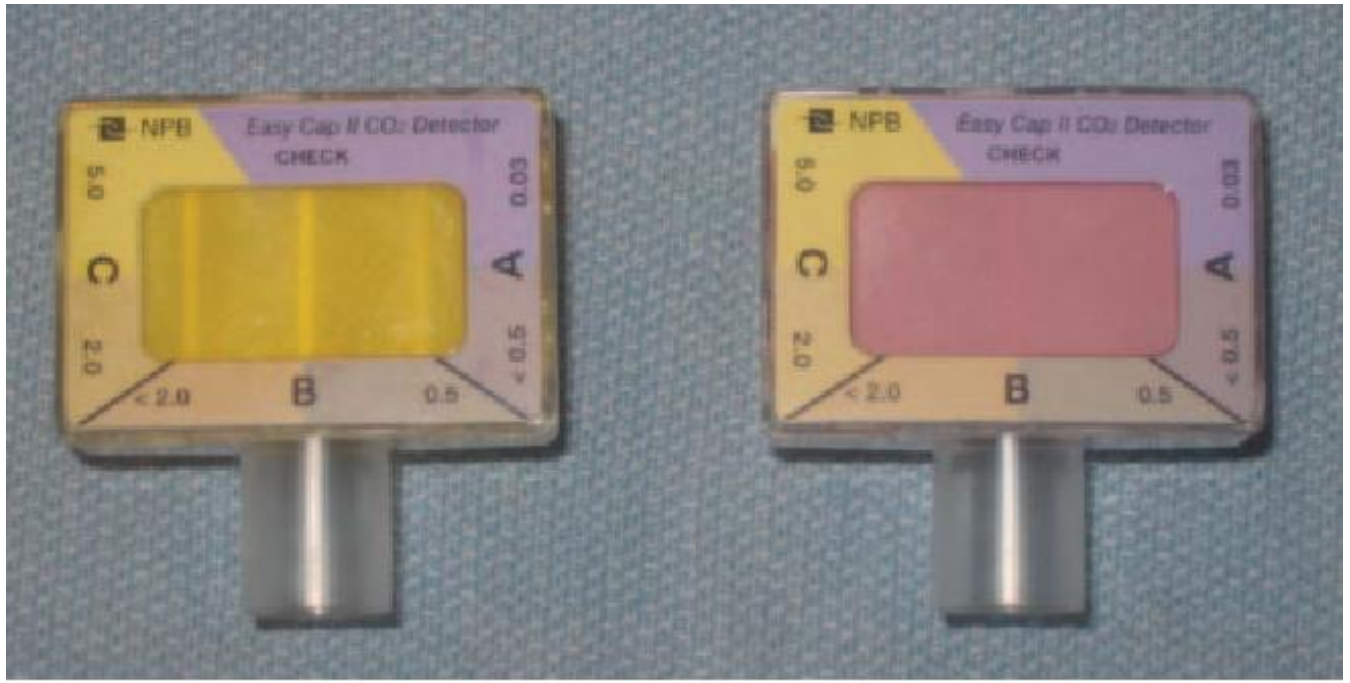
CO_2 Detection



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Indications for Chest Compressions

Despite adequate stimulation and effective ventilation with 100% oxygen

- Heart rate <60 bpm

  or

- Heart rate 60 to 80 bpm but not increasing

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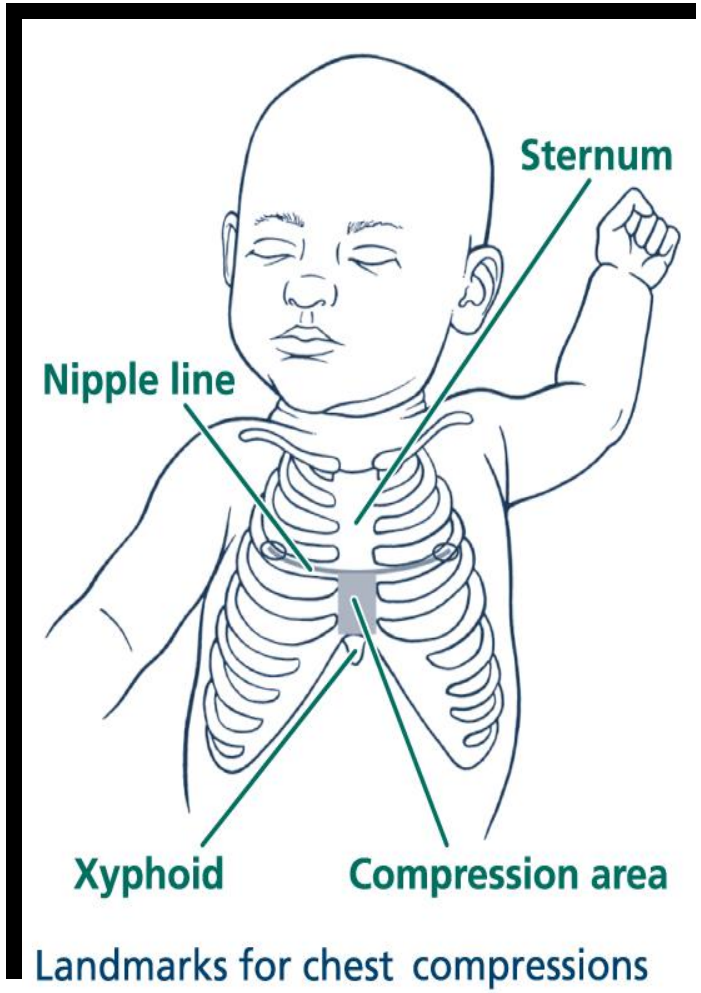
Chest Compressions: Positioning of Thumb

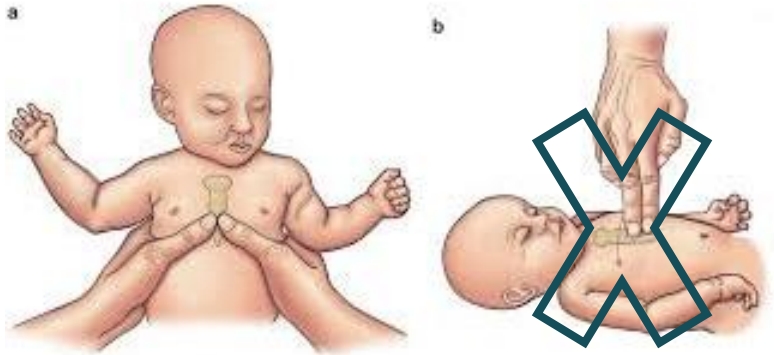
Apply pressure to lower third of sternum

Avoid xiphoid process

Always encircling chest technique rather than fingers



Landmarks for chest compressions



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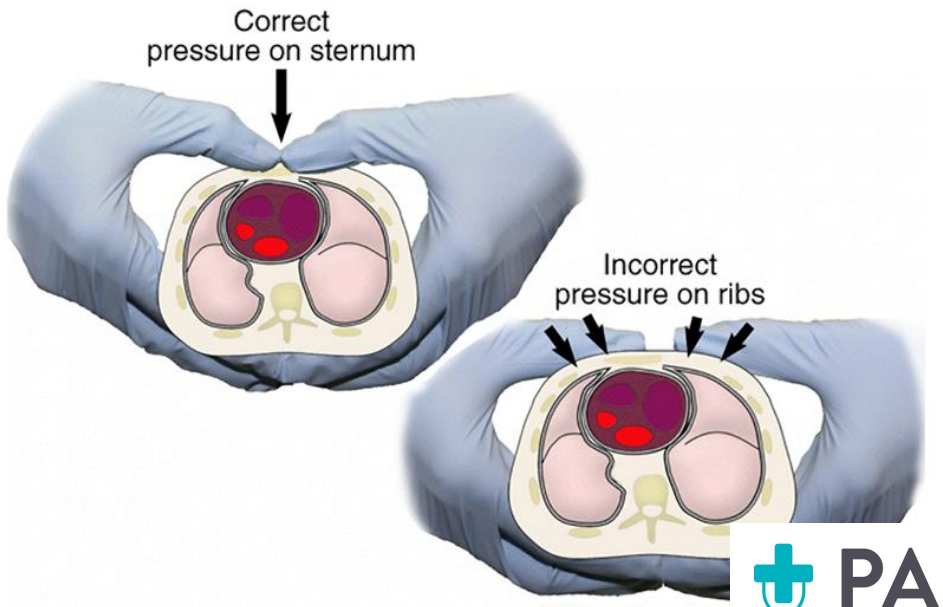
Chest Compressions:

- Apply pressure during compression on the sternum,releasing pressure to allow chest recoil and ventilation
- Compression/Ventilation 3:1
- 120 events /minute



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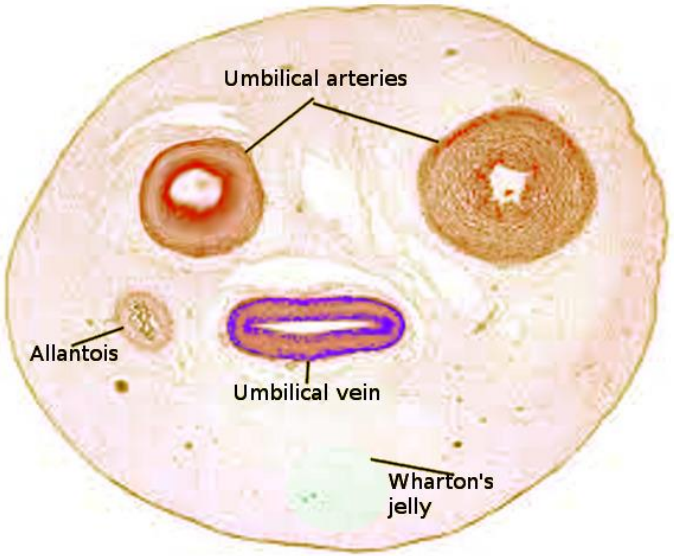
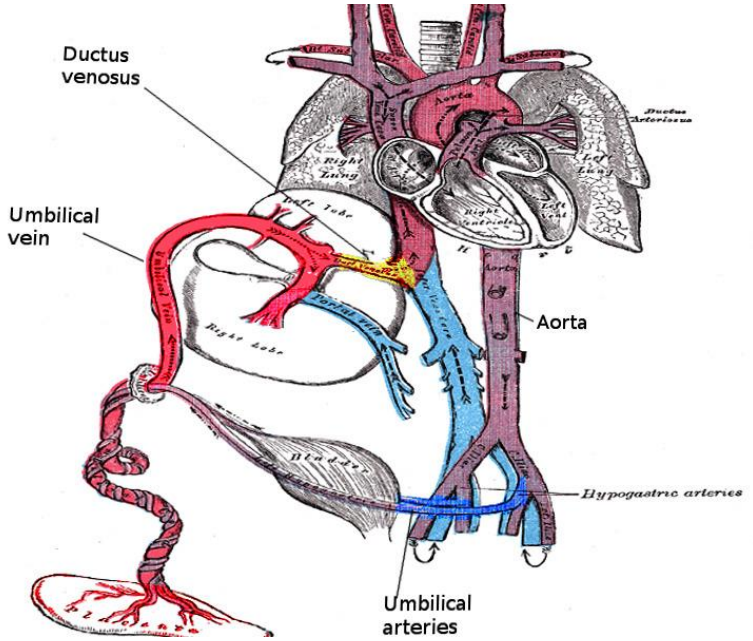
Umbilical Access





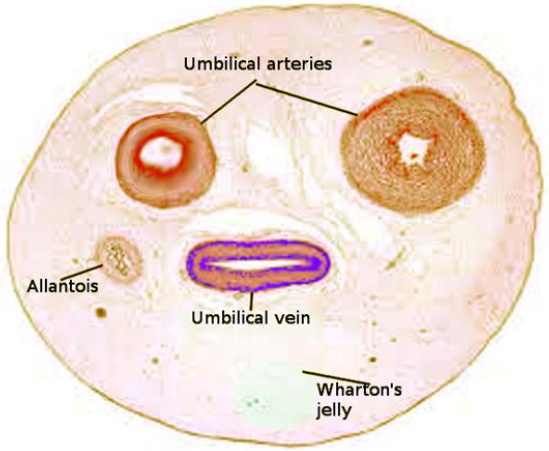
Medications

- Epinephrine/Adrenaline 0.2mls/kg of 1:10,000 IV/IO
- Dose may be repeated every 3 to 5 min
- ET route if no IV access:
  - 1ml/kg
  - no flush , PPV to distribute

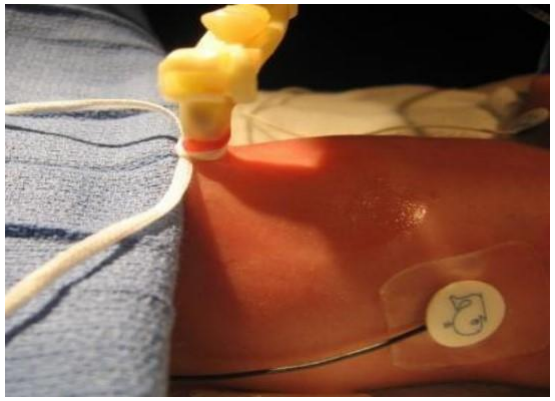
Neonatal Code Medications

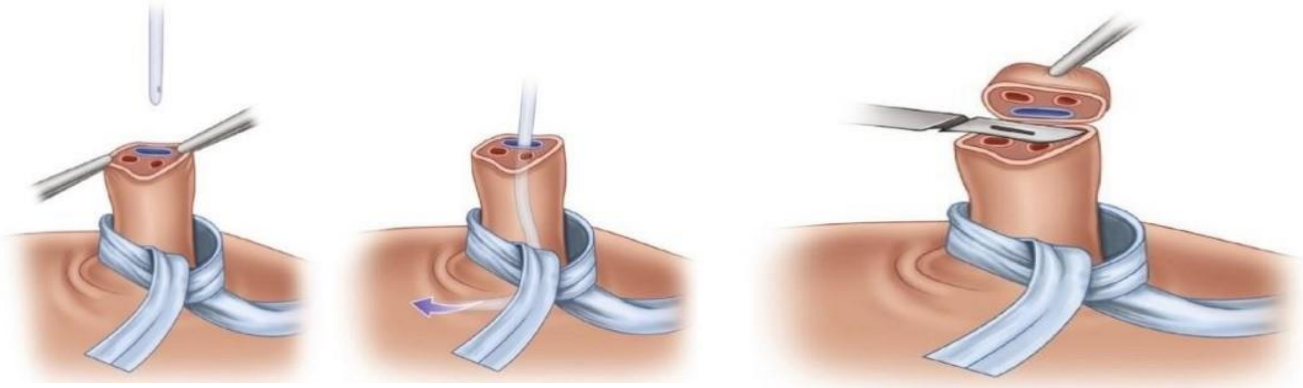
Drug	Dose*	0.5 kg	1 kg	2 kg	3 kg	4 kg	Administration
Epinephrine IV/IO Concentration: 0.1 mg/mL 1 mg/10 mL	0.02 mg/kg Equal to 0.2 mL/kg	IV Dose: 0.01 mg Volume: 0.1 mL	IV Dose: 0.02 mg Volume: 0.2 mL	IV Dose: 0.04 mg Volume: 0.4 mL	IV Dose: 0.06 mg Volume: 0.6 mL	IV Dose: 0.08 mg Volume: 0.8 mL	IV/IO rapid push Flush with 3 mL NS Repeat every 3-5 minutes if heart rate less than 60 bpm
Epinephrine ETT Concentration: 0.1 mg/mL 1 mg/10 mL	0.1 mg/kg Equal to 1 mL/kg	ET Dose: 0.05 mg Volume 0.5 mL	ET Dose: 0.1 mg Volume 1 mL	ET Dose: 0.2 mg Volume 2 mL	ET Dose: 0.3 mg Volume 3 mL	ET Dose: 0.4 mg Volume 4 mL	May administer while vascular access is being established ETT rapid push No need for flush. Provide PPV breaths to distribute into lungs.
Normal Saline IV 0.9% NaCl	10 mL/kg	5 mL IV	10 mL IV	20 mL IV	30 mL IV	40 mL IV	Give over 5-10 min

UVC insertion



- Put tie around base of umbilicus
- Clean with alcohol swab or sterile solution
- Cut the cord leaving 1-2cm of cord
- Insert line 3-5cms into vein
- Check for withdrawal of blood before use





Drugs and Oxygen

- Drugs are initially **not recommended**
  - **Ventilation first**
- Immediate resuscitation with oxygen can cause harm.
  - *About ¼ of resuscitated babies may need oxygen after 4-5 minutes of resuscitation.*
- Priority is **ventilation** – do not stop resuscitation to look for oxygen.
- The following drugs have no role in immediate newborn resuscitation
  - Sodium bicarbonate, aminophylline, hydrocortisone, 50%dextrose

Post-resuscitation Evaluation

- Temperature regulation
- Acid-base status
- Blood glucose
- Laboratory studies
- Chest x-ray

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ISBAR Communication

Identify	• Hello, my name is… • Am I speaking with…?
Situation	• The situation is…(what is the main reason you are calling?)
Background	• The background (*to this situation*) is…
Assessment	• My assessment (*of the situation*) is…
Recommendation	• I recommend that you/we now…

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Review of Learning

Summary

- Recognise cardiac arrest & start CPR
- Use structured approach to assessment
- Use PEWS, continue monitoring
- Communicate using ISBAR
- Give clinical treatment
- Agree care plan and review

Summary

- Recognise acute illness – ABCDE/Vital Signs
- Communicate effectively with ISBAR
- Follow the acute illness intervention cycle to identify, intervene and reassess
- Discuss and record the plan of care
- Consider implementing a safety huddle

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Case Simulations

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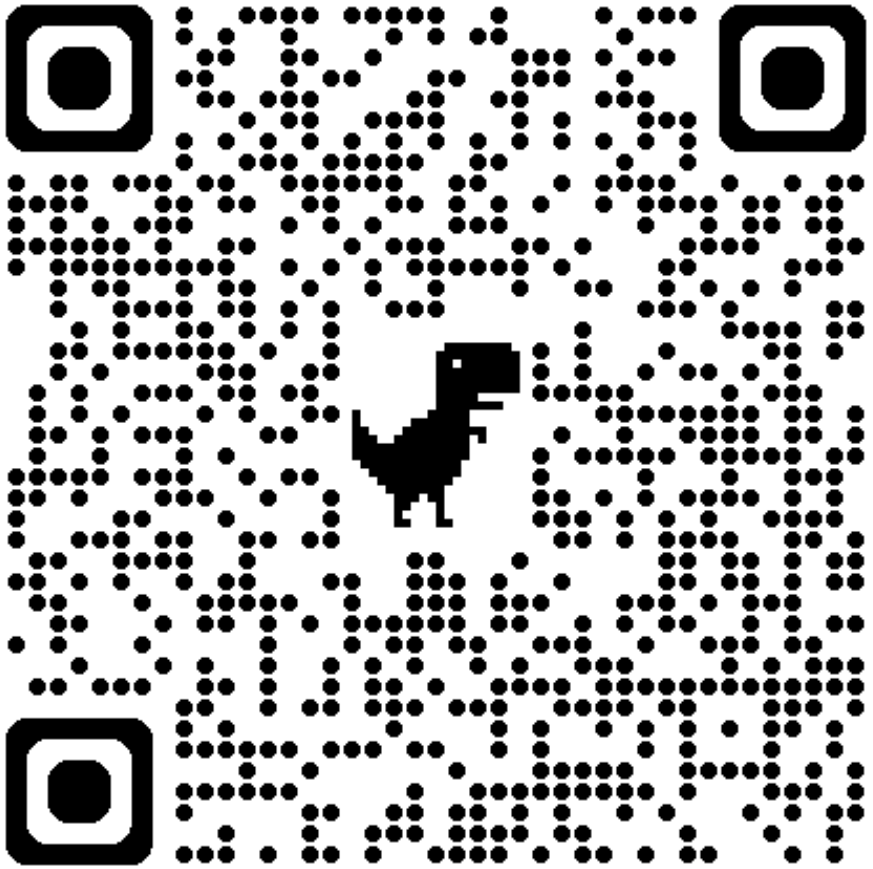
Testing

Testing



PAIRS basic MCQ Uganda May 2025

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Summary & Evaluation

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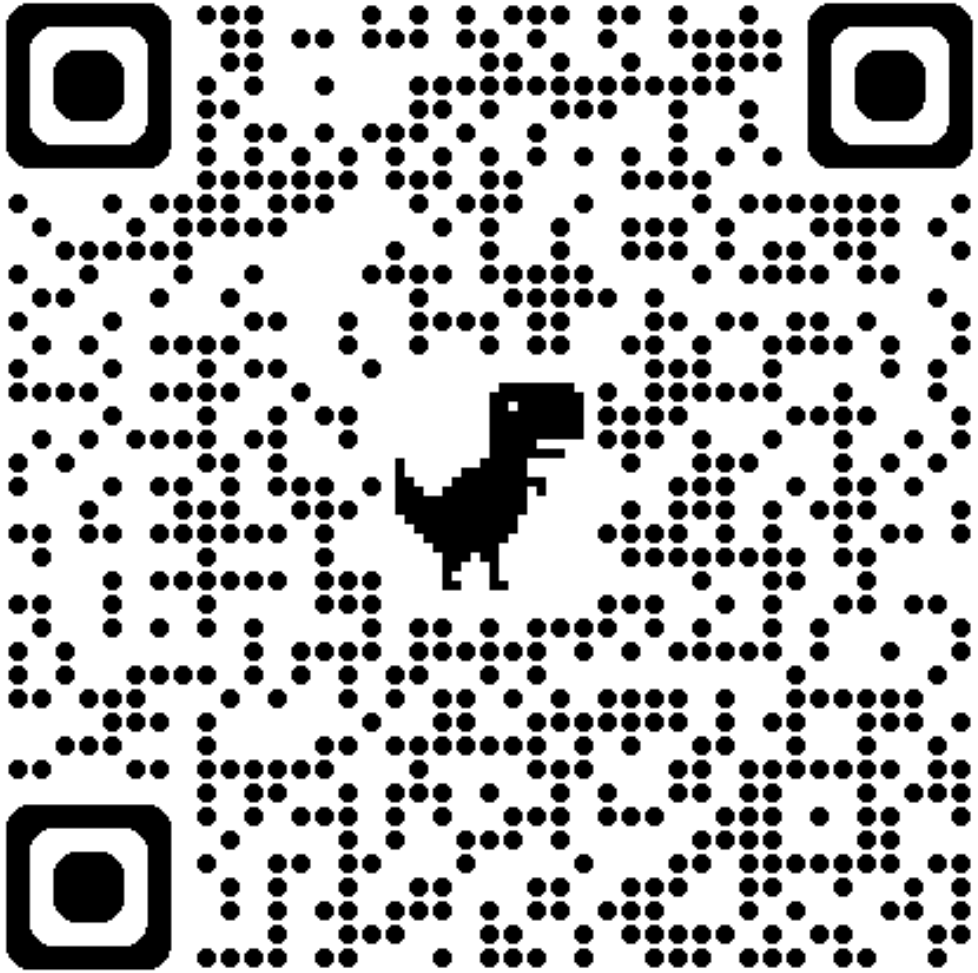
PAIRS Evaluation

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감사합니다
ευχαριστώ
merci

Weebale