

airway, and breathing (CAB); stabilizing the spine when indicated; treating shock; and reducing ICP (if present). Delayed treatment often leads to increased damage. As soon as emergency measures have been implemented—and in many cases concurrently—therapies for specific causes are begun. Because nursing care is closely related to medical management, both are considered here.

Continual observation of LOC, pupillary reaction, and vital signs is essential to manage CNS disorders. Regular assessment of neurologic status is an integral part of nursing care of unconscious children. The assessment frequency depends on the cause of unconsciousness, the LOC, and the progression of cerebral involvement. Intervals between observations may be as short as every 15 minutes or as long as every 2 hours. Significant alterations must be reported immediately.

Vital signs provide important information about the status of the unconscious child. The temperature is taken every 2 to 4 hours, depending on the patient's condition. Fevers can indicate an infective process, heat stroke, or hypothalamic regulatory abnormalities ([Sharma, Kochar, Sankhyan, et al, 2010](#)). Tachycardia is common with fevers, hypovolemic shock, or heart failure, whereas increased ICP or myocardial injury can cause bradycardia ([Sharma, Kochar, Sankhyan, et al, 2010](#)). Tachypnea is associated with lung pathology but quiet tachypnea indicates acidosis that can be associated with diabetic ketoacidosis or some poisonings ([Sharma, Kochar, Sankhyan, et al, 2010](#)). The LOC is assessed periodically and includes evaluating pupillary size, equality, and reaction to light. Signs of meningeal irritation such as nuchal rigidity are assessed. Assessment of LOC includes response to vocal commands, spontaneous behavior, resistance to care, and response to painful stimuli. Note any abnormal movement, changes in muscle tone or strength, and body position. Seizure activity is described according to the duration and body areas involved.

Pain management for the unconscious child requires astute nursing observation and management. Signs of pain include changes in behavior (e.g., increased agitation or rigidity); and alterations in vital signs (e.g., increased heart rate, respiratory rate, and blood pressure, and decreased oxygen saturation). Because these findings may not be specific for pain, the nurse should observe for their appearance during times of induced or suspected