PALS Systematic Approach Summary

Initial Impression

Your first quick (in a few seconds) "from the doorway" observation

Consciousness	Level of consciousness (eg, unresponsive, irritable, alert)
Breathing	Increased work of breathing, absent or decreased respiratory effort, or abnormal sounds heard without auscultation
Color	Abnormal skin color, such as cyanosis, pallor, or mottling

The purpose is to quickly identify a life-threatening problem.

Is the child unresponsive with no breathing or only gasping?

If YES:

- Shout for help.
- Activate emergency response as appropriate for setting.
- Check for a pulse.
- Begin lifesaving interventions as needed.

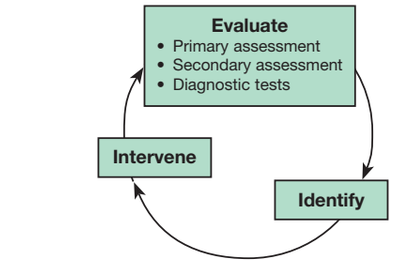
If NO:

- Continue the evaluate-identify-intervene sequence.

Use the ***evaluate-identify-intervene*** sequence when caring for a seriously ill or injured child.

- *Evaluate* the child to gather information about the child's condition or status.
- *Identify* any problem by type and severity.
- *Intervene* with appropriate actions to treat the problem.

Then repeat the sequence; this process is ongoing.



If at any time you identify a life-threatening problem, immediately begin appropriate interventions. Activate emergency response as indicated in your practice setting.

Evaluate

"Evaluate" consists of the primary assessment (ABCDE), secondary assessment, and diagnostic tests.

Primary Assessment

A rapid, hands-on ABCDE approach to evaluate respiratory, cardiac, and neurologic function; this step includes assessment of vital signs and pulse oximetry

Airway

Clear	Maintainable	Not maintainable

Breathing

Respiratory Rate and Pattern	Respiratory Effort	Chest Expansion and Air Movement	Abnormal Lung and Airway Sounds	Oxygen Saturation by Pulse Oximetry
Normal Irregular Fast Slow Apnea	Normal Increased • Nasal flaring • Retractions • Head bobbing • Seesaw respirations Inadequate • Apnea • Weak cry or cough	Normal Decreased Unequal Prolonged expiration	Stridor Snoring Barking cough Hoarseness Grunting Gurgling Wheezing Crackles Unequal	Normal oxygen saturation (≥94%) Hypoxemia (<94%)

Circulation

Heart Rate and Rhythm	Pulses		Capillary Refill Time	Skin Color and Temperature	Blood Pressure
Normal Fast (tachycardia) Slow (bradycardia)	***Central*** Normal Weak Absent	***Peripheral*** Normal Weak Absent	Normal: ≤2 seconds Delayed: >2 seconds	Pallor Mottling Cyanosis Warm skin Cool skin	Normal Hypotensive

Disability

AVPU Pediatric Response Scale				Pupil Size Reaction to Light		Blood Glucose	
Alert	Responds to **V**oice	Responds to **P**ain	**U**nresponsive	Normal	Abnormal	Normal	Low

Exposure

Temperature			Skin	
Normal	High	Low	Rash (eg, purpura)	Trauma (eg, injury, bleeding)

Secondary Assessment

A focused medical history (SAMPLE) and a focused physical exam

Diagnostic Tests

Laboratory, radiographic, and other advanced tests that help to identify the child's physiologic condition and diagnosis

Identify

Identify the child's problem as respiratory, circulatory, or both. Determine the type and severity of the problem(s). The table below lists common clinical signs that typically correlate with a specific type of problem and its severity.

Type		Severity
Respiratory	• Upper airway obstruction • Lower airway obstruction • Lung tissue disease • Disordered control of breathing	• Respiratory distress • Respiratory failure
Circulatory	• Hypovolemic shock • Distributive (eg, septic, anaphylactic) shock • Obstructive shock • Cardiogenic shock	• Compensated shock • Hypotensive shock
Cardiac Arrest		

Respiratory

Signs	Type of Problem	Severity
• Increased respiratory rate and effort (eg, retractions, nasal flaring) • Decreased air movement • Stridor (typically inspiratory) • Barking cough • Snoring or gurgling • Hoarseness	**Upper airway obstruction**	**Respiratory distress** • Some abnormal signs but no signs of respiratory failure **Respiratory failure** *One or more of the following:* • Very rapid or inadequate respiratory rate • Significant or inadequate respiratory effort • Low oxygen saturation despite high-flow oxygen • Bradycardia (ominous) • Cyanosis • Decreased level of consciousness
• Increased respiratory rate and effort (eg, retractions, nasal flaring) • Decreased air movement • Prolonged expiration • Wheezing	**Lower airway obstruction**	
• Increased respiratory rate and effort • Decreased air movement • Grunting • Crackles	**Lung tissue disease**	
• Irregular respiratory pattern • Inadequate or irregular respiratory depth and effort • Normal or decreased air movement • Signs of upper airway obstruction (see above)	**Disordered control of breathing**	

Circulatory

- Tachycardia
- Weak peripheral pulses
- Delayed capillary refill time
- Changes in skin color (pallor, mottling, cyanosis)
- Cool skin
- Changes in level of consciousness
- Decreased urine output

Signs of poor perfusion

Signs	Type of Problem	Severity
• Signs of poor perfusion (see above)	**Hypovolemic shock** **Obstructive shock**	**Compensated shock** • Signs of poor perfusion and *normal* blood pressure **Hypotensive shock** • Signs of poor perfusion and *low* blood pressure
• Possible signs of poor perfusion (see above) *or* • Warm, flushed skin with brisk capillary refill (warm shock) • Peripheral pulses may be bounding • Possible crackles • Possible petechial or purpuric rash (septic shock)	**Distributive shock**	
• Signs of poor perfusion (see above) • Signs of CHF	**Cardiogenic shock**	

Intervene

On the basis of your identification of the problem, intervene with appropriate actions. Your actions will be determined by your scope of practice and local protocol.