

PALS Systematic Approach- Simplified

Step 1) INITIAL IMPRESSION: *What you see from the doorway*

LOOK FOR: A B C's

Apppearance (Alertness)

Breathing (Fast, slow, retractions)

Circulation/Color (Rash, pale, mottled)

** Life-threatening issues? Get help and fix them!*

** No life-threatening issues? Evaluate*

Step 2) PRIMARY ASSESSMENT: *Evaluate patient. Rapidly go thru the ABCDE's*

A- Airway: Patent?

B- Breathing: Labored, fast or slow, retractions, O2 sat.

C- Circulation: HR, cap refill, skin color, BP

D- Disability: AVPU, pupils, glucose

E- Exposure: Look for trauma, rash, burns

Step 3) SECONDARY ASSESSMENT: *Sample History*

S- Signs and Symptoms (We see signs, they tell us symptoms)

A- Allergies (Anaphylaxis)

M- Medications (Interactions)

P- Past Medical History (Pertaining to illness)

L- Last Meal (Diabetes, Surgery, Intubation)

E- Events (What were they doing)

Step 4) IDENTIFY: *Is it Respiratory, Circulatory or BOTH?*

RESPIRATORY: Upper Airway (Croup, FB) **Lower Airway** (Asthma, Bronchiolitis) **Lung Tissue** (Pneumonia, Pulmonary Edema)
Disordered Control of Breathing (ICP, Drugs, Seizure)

CIRCULATORY: Hypovolemic Shock (Fluid loss, N/V) **Obstructive Shock** (PE, Pneumothorax) **Distributive Shock** (Sepsis, Anaphylaxis) **Cardiogenic Shock** (Tachy, Brady, MI, Myopathy)

Step 4) INTERVENE: *Fix what is wrong*

REPEAT AS NEEDED