

PALS Assessment

Evaluate—Identify—Intervene

Peds Assessment Triangle

Alert
Breathing
Skin Color

Primary Assessment

Airway—Patent? Maintain?

Breathing—SaO₂? Rate?
↑ Work of Breathing?
Require Supplemental O₂?

Circulation—

- Skin Color/Temp
- Heart Rate-Heart Rhythm
- Blood Pressure
- Pulses
- Cap Refill

Disability—
AVPU Response
GCS— Pupillary Response

Exposure

Detailed Physical
“Head to Toe” Assessment

Secondary Assess-

HISTORY

Signs and Symptoms
Allergies
Medications
Past Medical History
Last Meal
Events

Diagnostic Test

Bedside Glucose
ABG
PETCO₂ Monitoring
Chest X-Ray
Expiratory Peak Flow
CAT Scan

Respiratory Emergency

Respiratory Distress vs Failure?

SaO₂— 94-99%

Upper Airway

- Croup
- Anaphylaxis
- Foreign Body

Lower Airway

- Asthma/RAD
- Bronchiolitis

Lung Tissue Disease

- Infectious Pneumonia
- Aspiration
- Chemical Exposure
- ARDS
- Pulmonary Edema

Disorder of Breathing

- Drug overdose
- Poisoning
- Increased ICP
- Neuromuscular Disease

Circulatory Emergency

Shock **Rhythm**

Hypovolemic
- Nonhemorrhagic
- Hemorrhagic
20mL/kg

Obstructive
- Cardiac Tamponade
- Tension Pneumo
- Pulmonary Emboli
- Congenital Lesions

Distributive
- Septic
10-20mL/kg
- Anaphylactic
- Neurogenic

Cardiogenic
- pulmonary edema
- venous congestion
- cardiomegaly
Fluids 5-10 mL/kg

Tachycardia
0-1y/o >220 BPM
> 1 y/o >180 BPM

Bradycardia
HR < 60 BPM
With Cardiopulmonary compromise
CPR

Pulseless
VF/VT
Or
PEA/Asystole

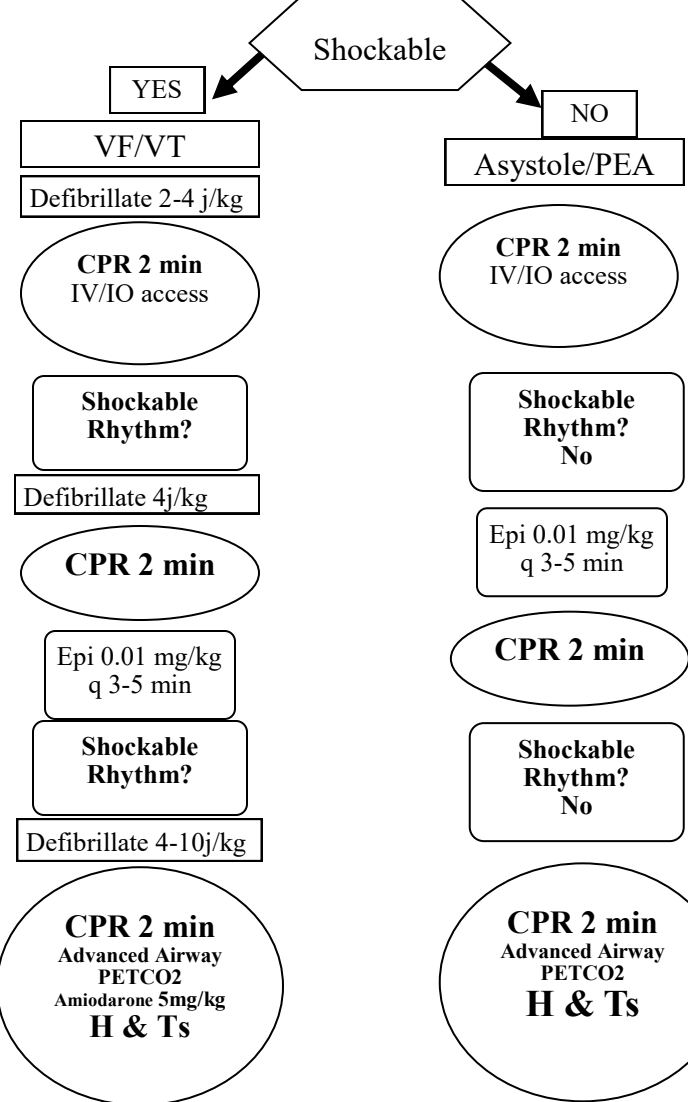
Evaluate B/P
PEDIATRIC HYPOTENSION

- 0-28 days <60 systolic
- 1-12 months <70 systolic
- 1-10 y/o <70 systolic (AGE, IN YEARS x2)
- > 10 y/o <90 systolic

NOTE:
NS & LR are
Isotonic crystalloid
The standard IV fluids used for initial volume resuscitation

CARDIAC ARREST

Call for Help/Activate Code Team
START CPR (Hard and Fast)
Give Oxygen
Attach Monitor/Defibrillator



H & Ts

- Hypovolemia
- Hypoxia
- Hydrogen Ion (H⁺)
- Hypo/hyperkalemia
- Hypoglycemia
- Hypothermia
- Toxins
- Trauma;
- Tamponade
- Tension Pneumo
- Thrombosis
- Pulmonary
- Coronary

PALS Tachycardia (2020 Guidelines)

Identify and Treat Cause

Maintain Airway
Monitor Pulse Oximetry and B/P
Oxygen, IV/IO, Cardiac Monitor, 12 Lead if available

Evaluate QRS Width Evaluate Rhythm

Probable Sinus Tach

Hx suggests known cause
P wave present
Regular R-R and PR interval
Infants: ≤ 220 BPM
Children: ≤ 180 BPM

Treat Reversible Causes Hs & Ts

Probable SVT

Vague, non-specific hx
Abrupt Rate Changes in HR
P waves absent/abnormal
Regular R-R and PR interval
Infants: > 220 BPM
Children: > 180 BPM

Cardiopulmonary Compromise?

Hypotension
Altered Mental Status
Signs of Shock

NO

Consider Vagal Maneuvers

Establish vascular access

Consider
adenosine 0.1 mg/kg IV/IO (max 6 mg)
Rapid push and flush
Second dose
adenosine 0.2 mg/kg
Rapid push and flush

YES

Consider Vagal Maneuvers NO DELAYS

If IV/IO present, give adenosine
OR
IF IV/IO Access is not available, or if adenosine is ineffective,
SYNC Cardioversion

Probable V Tach

QRS wide $> .09$ sec

Cardiopulmonary Compromise?

Hypotension
Altered Mental Status
Signs of Shock

NO

Consider Adenosine if regular and monomorphic

Expert consultation advised

YES

SYNC Cardioversion

CARDIOVERSION
0.5 to 1 J/kg 1st Shock (may increase if initial dose is ineffective)
Sedate if possible before Cardioversion 2j/kg—2nd shock

Bradycardia

< 60 BPM

CARDIOPULMONARY COMPROMISE??

Identify and Treat Underlying Causes

- **Airway and Breathing**
SaO₂? Oxygen? Respiratory Failure?
- **Circulation**
Cardiac Monitor—Blood Pressure-- Skin Color—Cap Refill
- **IV/ IO established**
- **12 Lead EKG**

HR < 60 BPM
If Cardiopulmonary is compromised then
START CPR

Cardiopulmonary Compromise

- Altered Mental Status
- Signs of Shock
- Respiratory Failure
- Hypotension

Bradycardia Persists?

NO

Airway
Breathing
Circulation
Observe
CONSIDER EXPERT CONSULTATION

YES

- Epinephrine
0.01 mg/kg every 3-5 min..

Bradycardia Persists?

NO

YES

- Repeat Epinephrine
- Consider Atropine
- Consider Pacing
- Treat Hs & Ts