

Pediatric Systematic Approach Summary

Evaluate

"Evaluate" consists of the initial assessment, primary assessment, and secondary assessment.

Initial Assessment

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

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

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

Is the child unresponsive with no breathing or only gasing?

If yes

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

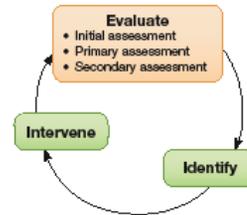
If no

- 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.

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
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Breathing

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

Circulation

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

Disability

AVPU Pediatric Response Scale				Pupil Size: Reaction to Light		Blood Glucose	
A lert	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 and a focused physical exam

Diagnostic Assessments

Laboratory, radiographic, and other advanced tests that help to identify the child's 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 <ul style="list-style-type: none"> • Upper airway obstruction • Lower airway obstruction • Lung tissue disease • Disordered control of breathing 	<ul style="list-style-type: none"> • Mild respiratory distress • Severe respiratory distress
Circulatory <ul style="list-style-type: none"> • Hypovolemic shock • Distributive (eg, septic, anaphylactic) shock • Obstructive shock • Cardiogenic shock 	<ul style="list-style-type: none"> • Compensated shock • Hypotensive shock
Cardiac Arrest	

Respiratory

Signs	Type of Problem	Severity
<ul style="list-style-type: none"> • Increased respiratory rate and effort (eg, retractions, nasal flaring) • Decreased air movement • Stridor (typically inspiratory) • Barking cough • Hoarseness • Snoring or gurgling 	Upper airway obstruction	Mild respiratory distress <ul style="list-style-type: none"> • Some abnormal signs, but no signs of severe distress <ul style="list-style-type: none"> – Increased respiratory rate – Increased respiratory effort (eg, nasal flaring, retractions) – Abnormal airway and lung sounds (eg, stridor, grunting, wheezing) – Tachycardia – Pale, cool skin – Changes in level of consciousness Severe respiratory distress <i>One or more of the following:</i> <ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Increased respiratory rate and effort (eg, retractions, nasal flaring) • Decreased air movement • Prolonged expiration • Wheezing 	Lower airway obstruction	
<ul style="list-style-type: none"> • Increased respiratory rate • Increased respiratory effort (especially during inspiration) • Decreased air movement • Grunting • Crackles • Head bobbing 	Lung tissue disease	
<ul style="list-style-type: none"> • Normal or decreased air movement • Shallow breathing with inadequate effort (frequently resulting in hypoxemia and hypercarbia) • Variable respiratory effort • Variable or irregular respiratory rate and pattern (possibly tachypnea alternating with bradypnea) • Central apnea (ie, apnea without any respiratory effort) 	Disordered control of breathing	

Circulatory

Signs	Type of Problem	Severity
Signs of poor perfusion <ul style="list-style-type: none"> • Tachycardia • Weak or absent peripheral pulses • Normal or weak central pulses • Delayed capillary refill time • Changes in skin color (pallor, mottling, cyanosis) • Cool skin • Decreased level of consciousness • Decreased urine output 	Hypovolemic shock	Compensated shock <ul style="list-style-type: none"> • Signs of poor perfusion and normal systolic blood pressure Hypotensive shock <ul style="list-style-type: none"> • Signs of poor perfusion and low systolic blood pressure (hypotension)
<ul style="list-style-type: none"> • Possible signs of poor perfusion (see above) <i>or</i> • Warm, flushed skin with brisk capillary refill • Peripheral pulses may be bounding • Possible crackles • Possible petechial or purpuric rash (septic shock) 	Distributive 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.