ABCDE Assessment

	ASSESS	POSSIBLE ACTIONS
AIRWAY	**Is the Airway –** ▪ **PATENT** ▪ **AT RISK** ▪ **OBSTRUCTED**	→ Suction if indicated, → Head positioning, → Airway adjuncts, → Administer oxygen, → Call 2222 if at risk.
BREATHING	▪ Respiratory rate ▪ Spo2 ▪ Accessory muscle use ▪ Noises+/- Percussion, Palpation & Auscultation ▪ Position/posture	→Administer high flow O2 (NB: caution with type 2 Respiratory failure), → Summon help → Monitor SpO2/ABGs → Treat underlying cause, → Call 2222 if not breathing.
CIRCULATION	▪ Pulse ▪ Blood pressure ▪ CRT ▪ Core temp/colour ▪ Urine output ▪ Conscious level ▪ Other losses i.e. drains	→ Obtain IV access, → Administer O2, → Summon help, → Prepare fluid challenge, → Initiate Fluid Balance Chart → Call 2222 if no circulation
DISABILITY	▪ AVPU/GCS, ▪ ABG's & treat Hypoxia or Hypovolaemia, ▪ Blood glucose ▪ Drugs.	→ Bedside blood glucose → Check drug chart → Assess pupils → Nurse in lateral position → Summon help
EXPOSURE	▪ Top to Toe examination, ▪ Look for evidence of blood loss / rashes / drains / wounds etc, ▪ Temperature	→ Control bleeding → Treat any underlying conditions identified → Temperature control → Reassess → Maintain patient's dignity

Remember:

To record all observations on NEWS chart & document any deterioration in the notes.

If at any point during your assessment you are concerned about your patient **- Call for help.**