| A | Airway | Look | - For any signs of airway obstruction.  
- For evidence of mouth/throat/swelling/haematoma.  
- For security of artificial airway.  
| Listen | - For noisy breathing e.g. gurgling, snoring or stridor.  
| Feel | - For the presence of air movement.  
- For security of artificial airway.  

| B | Breathing | Look | - At the chest wall movement, to see if it is normal and symmetrical.  
- To see if the patient is using their neck and shoulder muscles to breathe (accessory muscles).  
- At the patient to measure their respiratory rate.  
| Listen | - To the patient talking to see if they can complete full sentences.  
- For noisy breathing e.g. stridor, wheezing.  
| Feel | - For the position of the trachea to see if it is central.  
- For the surgical emphysema or crepitus.  
- If the patient is diaphoretic (sweaty).  

| C | Circulation | Look | - At the skin colour for pallor and peripheral cyanosis.  
- At the capillary refill time.  
- At the patient’s central venous pressure and jugular venous pressure.  
| Listen | - To the patient for complaints of dizziness and headaches.  
- For patient’s blood pressure and heart sounds.  
| Feel | - For patient’s response to external stimuli.  
- For muscle power and strength.  
- Your patient’s hands and feet to see if they are warm or cold.  
- Your patient’s peripheral pulses for presence, rate, quality, regularity and equality.  

| D | Disability | Look | - At the level of consciousness.  
- For facial symmetry, abnormal movements, seizure activity or absent limb movements.  
- At pupil size, equality and reaction to light.  
| Listen | - To patients response to external stimuli and pain.  
- For slurred speech.  
- For patient’s orientation to person, place and time.  
| Feel | - For patient’s response to external stimuli.  
- For muscle power and strength.  

| E | Exposure | Look | - For any bleeding e.g. investigate wounds and drains that may be hidden by bed clothes.  
| Listen | - For air leaks in drains.  
- For bowel sounds.  
| Feel | - The patient’s abdomen.  

| F | Fluids | Look | - At the observation and fluid charts, noting the fluid input and output.  
- At losses from all drains and tubes.  
- At the amount and colour of the patient’s urine and urinalysis results.  
| Listen | - For patient’s complaints of thirst.  
| Feel | - The skin turgor.  

| G | Glucose | Look | - At blood glucose levels.  
- For signs of low glucose, including confusion and decreased conscious state.  
- At medication chart for insulin and oral hypoglycaemics.  
| Listen | - For patient’s complaints of thirst.  
- For patient’s orientation to person, time and place.  
| Feel | - If the patient is diaphoretic (sweaty, cold or clammy).  

Give oxygen  
- Based on your assessment (above) decide on an appropriate oxygen flow rate or percentage. If in doubt commence on 4L/min on a Hudson mask and increase as indicated by oxygen saturation or patient condition.  

Position your patient  
- Position your patient to optimise their breathing – usually this is as upright position as possible and as tolerated by the patient.  
- Place the patient in the left lateral position if they are unconscious but have adequate breathing and circulation and where there is no evidence of spinal injury.  

Call for help if you can’t manage  
- Establish IV if not present, +/- fluids.  

Never leave a deteriorating patient without a priority management and review plan  
- Document and communicate clearly.  
- All treatments provided.  
- Outcomes of treatment implemented.  
- What care is still required.  
- The plan should include expected outcomes and when the patient will be reviewed again.